Research & Demonstrations In Health Care Financing

Status Report

Fiscal Year 1994 Edition

Health Care Financing

Status Report

The Office of Research and Demonstrations (ORD), Health Care Financing Administration (HCFA), directs more than 400 research, evaluation, and demonstration projects. A central focus is on program expenditures as they relate to payment, coverage, eligibility, and management alternatives under Medicare and Medicaid. Study activity also examines program impact on beneficiary health status, access to services, utilization, and out-of-pocket expenditures. The behavior and economics of health care providers and the overall health care industry also are topics of investigation.

These activities are carried out by three major components—the Office of Research, the Office of Demonstrations and Evaluations, and the Office of Operations Support. The Office of Research conducts and supports data collection efforts and research on health care providers, payment approaches, beneficiary behavior, and health care utilization. The Office of Demonstrations and Evaluations funds, manages, and evaluates pilot programs that test new ways of delivering and financing Medicare and Medicaid services. The Office of Operations Support provides ORD-wide administrative direction for its research, demonstration, and evaluation projects, which includes the budget and accounting operations; grants, cooperative agreements, and contracts-award process; and publications and information resources program.

This report provides basic information on active intramural and extramural projects in a brief format. These projects are used to assess new methods and approaches for providing quality health care while containing costs, and they often provide the basis for making critical policy decisions on health care financing issues. Projects are arranged according to ORD budget priority areas. The synopsis on each project includes an identification number, the title, project number, project period, name of principal investigator, name and address of awardee, contractor, or grantee organization, Federal project officer with primary responsibility for the project, Federal statute, a brief description, and the status of the project as of September 30, 1994. When a project involves research and development funds, the total funding amount for the life of the project is included. Remaining extramural projects are being conducted with waivers that permit innovations to financing and delivery of health services under the Medicare and Medicaid programs. Intramural ORD research studies also are described.

This is the fifteenth edition of the *Status Report*. Updated editions are produced on an annual basis. The information presented should be of use to policy officials, health planners, and researchers in examining the range of research and demonstration activities that are undertaken by ORD and the implications of results and findings.

In this year's edition, we have added several appendixes to make the *Status Report* more useful to our readers in identifying and locating projects that are of particular interest. These appendixes are: a topical "keyword" index of projects, an alphabetical index of project titles, an index of names and addresses of awardee organizations, an index of principal investigators and HCFA project directors, a geographic index of research and demonstration projects carried out in each State and internationally, and a directory of the names and telephone numbers of HCFA project officers and project directors.

Health Care Financing

Status Report

Research and Demonstrations
in Health Care Financing
Fiscal Year 1994 Edition

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
Baltimore, Maryland 21207

HCFA Pub. No. 03363
January 1995

Requests to be placed on our mailing list to
receive notification of future publications
as they become available should be sent to:
Health Care Financing Administration,
Office of Research and Demonstrations,
Publications and Information Resources Branch,
Room 1-A-9 Oak Meadows Building,
6325 Security Boulevard,
Baltimore, Maryland 21207.

For sale by the U.S. Government Printing Office
Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-9328
ISBN 0-16-048065-5

Contents

Health Care Systems Reform and Financing

92-022 Actuarial Methods for Improving Health Care Financing Administration Payment to Risk Health Maintenance Organizations

Project No.:	17-C-90033/3
Period:	February 1992–February 1995
Funding:	$ 449,510
Award:	Cooperative Agreement
Principal Investigator:	Charles William Wrightson
Awardee:	Actuarial Research Corporation 6928 Little River Turnpike, Suite E Annandale, VA 22003
HCFA Project Officer:	Gerald F. Riley Division of Beneficiary Studies

Description: This project will assess four alternatives to the adjusted average per capita cost method for paying Medicare health maintenance organizations. They are:

- Partial capitation: Some services are paid for on a prospective capitation basis and others are paid retrospectively on a cost basis.
- Reinsurance with Medicare as the reinsurer.
- Prospective experience rating in which a prospective payment will be made on the basis of past experience.
- Select and ultimate rates: This method takes into account initial favorable selection with an adjustment for regression to the mean over time.

Status: Analysis is under way. A draft final report is expected within the next several months.

94-107 Alternative Health Risk Adjusters for the Medicare Risk Program

Project No.:	17-C-90366/3
Period:	September 1994–September 1996
Funding:	$ 501,581
Principal Investigator:	Sheldon Retchin, M.D.
Awardee:	Virginia Commonwealth University P.O. Box 980568 Richmond, VA 23298-0568
HCFA Project Officer:	Renee Mentnech Division of Beneficiary Studies

Description: The goal of this project is to develop an implementable risk adjuster that is based on a history of cancer, heart disease or stroke, and severity of illness; the length of time since the last hospital stay; and comorbidities. The predictive power from using history of serious illness will be compared to the predictive power of two existing risk adjusters—the diagnostic cost group and ambulatory care group models. Both predictive accuracy and operational features will be compared. The study is intended to yield information on the extent to which the health risk adjusters are likely to eliminate over/underpayment in the Medicare risk program under various assumptions about biased selection in health maintenance organizations. The ultimate objective is to revise the risk adjustment procedures used in the Medicare risk program. The proposal also suggests that this work could provide a framework for risk adjustment for the population under 65 years of age.

Status: This project has recently been awarded, and work will begin shortly.

94-072 Analysis of the Validity of the Discretionary Component of Diagnostic Cost Group Risk Adjusters

Project No.:	17-C-90295/1
Period:	September 1994–August 1995
Funding:	$ 97,341
Award:	Cooperative Agreement
Principal Investigator:	Frank W. Porell, Ph.D.
Awardee:	DataChron Health Systems, Inc. 763 Massachusetts Avenue, Suite 7 Cambridge, MA 02139
HCFA Project Officer:	Michael Kendix, Ph.D. Division of Beneficiary Studies

Description: The study investigates the validity of the discretionary component of the diagnostic cost group (DCG) risk classification system and three other methods for distinguishing discretionary and nondiscretionary diagnoses. This entails an assessment of the extent to which the differences among health maintenance organizations, fee-for-service providers, and geographic variations in hospital admissions rates can be associated with variations in rates of discretionary hospital admissions. In addition, this study examines the relationship between the aggregate rate of nondiscretionary admissions and mortality rates. The empirical performance of the DCG discretionary ratings, in this regard, is compared with the performance of several alternative classifications of discretionary admissions.

Status: This project is in the early developmental stage.

82-001 **Arizona Health Care Cost-Containment System**

Project No.:	11-P-98239/9
Period:	June 1982–September 1997
Award:	Grant
Principal Investigator:	Mabel Chen, M.D.
Awardee:	Arizona Health Care Cost-Containment System Administration 801 East Jefferson Phoenix, AZ 85034
HCFA Project Officer:	Ronald W. Lambert Division of Health Systems and Special Studies

Description: This project is designed to test the effectiveness of establishing, under Title XIX of the Social Security Act, a Medicaid program based on competitive principles, including primary care physicians acting as gatekeepers, prepaid capitated contracts, competitive bidding, use of nominal copayments, and limited restrictions on freedom of choice. Although acute services continue to be provided by health plans, long-term care (LTC) services are provided through capitated contracts by the State with five Arizona counties and two LTC contractors. The major features of the Arizona Long-Term Care System (ALTCS) are:

- Program contractors are at financial risk for providing services through prepaid capitation payments made by the State.
- Prevention of member dumping and promotion of cost effectiveness are accomplished by bundling LTC and acute care services into one capitation rate.
- Clients at risk of being institutionalized are treated in the least restrictive, most cost-effective manner by providing them with a full continuum of LTC services from skilled nursing home care to home care. Home- and community-based use is limited to 35 percent of total LTC eligibles for the elderly and physically disabled population. There is no such limit for the developmentally disabled population.
- LTC services are procured through competitive bidding and selective contracting.
- Strong program controls are employed, including a stringent preadmission screening program, case management, quality assurance, quality control, uniform accounting and reporting, and auditing.

Status: The Arizona Health Care Cost-Containment System (AHCCCS) began operation on October 1, 1982, and initially covered only acute care services. The ALTCS component was approved as part of a 5-year extension of the AHCCCS demonstration from October 1, 1988, through September 30, 1993. On January 6, 1993, the Health Care Financing Administration (HCFA) granted a 1-year extension to the demonstration. On August 16, 1994, HCFA approved an additional 3-year extension to the waivers through September 30, 1997.

94-092 **Assessing the Compatibility of an All-Payer Ratesetting System and Managed Competition: The Maryland Experience**

Project No.:	18-C-90372/1
Period:	September 1994–September 1995
Funding:	$ 153,763
Award:	Cooperative Agreement
Principal Investigator:	Stanley Wallack, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Payment and Economic Studies

Description: The purpose of this project is to analyze the effect of two features of the Maryland all-payer system on hospital costs and utilization rates of health maintenance organizations (HMOs) from 1986 to 1992. First, rates are set for individual services and reimbursement is provided for services actually rendered. Second, different rates are set for different hospitals. The proposal will examine the hypothesis that Maryland HMOs lower expenditures by limiting services and choosing less expensive hospitals.

Status: This project is in the early developmental stage.

93-040 **Assessing the Viability of Developing All-Payer Systems for Health Care Services: The Urban Institute** (Formerly, Assessing the Viability of All-Payer Systems for Health Care Services: The Urban Institute)

Project No.:	500-92-0024DO04
Period:	May 1993–December 1994
Funding:	$ 1,325,480
Award:	Delivery Order in Master Contract
Principal Investigator:	John Holahan, Ph.D.
Awardee:	The Urban Institute

(See page 215)

HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment and Economic Studies

Description: The purposes of this delivery order are to assess the viability of constructing an all-payer system for health care services for providers, focusing on hospitals and physicians, and to determine whether such a system would be feasible and desirable. This delivery order will examine a number of practical data-driven issues that must be resolved in creating an all-payer system. The goals for this research include:

- Obtaining and analyzing data to be used in the construction of conversion factors, weights, costs per discharge, case mix indices, and other statistics necessary for constructing all-payer hospital and physician systems.
- Determining what data and other resources would be necessary and are available to create and implement such systems.
- Obtaining and analyzing such data.
- Assessing the distributional implications of all-payer systems.

Status: Work on this project is in progress.

94-091 Business Health Care Purchasing Coalitions

Project No.:	18-C-90329/9
Period:	September 1994–March 1996
Funding:	$ 198,667
Award:	Cooperative Agreement
Principal Investigator:	Peter Jacobson
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Payment and Economic Studies

Description: The purpose of this project is to assess the success of business health care purchasing alliances in reducing health care costs and in expanding access to previously uninsured employees. The project consists of two phases. The first phase of the project will develop case studies of six business coalitions and two State-sponsored health insurance purchasing cooperatives. The second phase of the project will consist of a quantitative analysis of the rates of growth in expenditures or premiums of alliance members relative to regional and national rates of growth.

Status: This project is in the early developmental stage.

93-008 Coordinating Health Care Reform with the U.S. Territories and Possessions: Case of Puerto Rico

Project No.:	18-C-90240/2
Period:	January 1993–January 1995
Funding:	$ 290,482
Award:	Cooperative Agreement
Principal Investigator:	Enrique Baquero
Awardee:	Instituto de Administracion y Politica de Salud de Puerto Rico P.O. Box 193745 Hato Rey, PR 00919-3745
HCFA Project Officer:	Gerald F. Riley Division of Beneficiary Studies

Description: The study will compare the structural organization of the health care system in Puerto Rico to that of a selected sample of States. The investigators want to evaluate health care policies in the sampled States and to determine their possible relevance for Puerto Rico. The project will develop alternative proposals for reform of the health care system in Puerto Rico. Objectives are to:

- Explain levels of expenditures and growth, access, utilization, payment, and insurance markets in Puerto Rico.
- Identify initiatives in other States and how they may be transferred to Puerto Rico given the similarities in the health systems.
- Explore initiatives to increase private insurance for small group markets.
- Explore ways to increase Medicare Part B participation.
- Study ways to adapt to national health care reform initiatives.

Some data gathering and analysis will be undertaken. Comparative and descriptive data will be collected on the health status of the Puerto Rican population, its health care system, and the history and unique causes of cost escalation. The project is expected to lay the groundwork for future decisions by defining the issues and problems for which solutions will be needed.

Status: Two progress reports have been prepared that describe the organization and characteristics of the health care system in Puerto Rico. A draft final report is expected in 1995.

94-001 **Developing Methodologies for Assessing the Effectiveness of Medicare Parts A and B Medical Review**

Project No.:	500-92-0021DO03
Period:	October 1993–September 1994
Funding:	$ 339,926
Award:	Delivery Order in Master Contract
Principal Investigator:	Allen Dobson, Ph.D.
Awardee:	Lewin/VHI, Inc. (with The Johns Hopkins University) (See page 213)
HCFA Project Officer:	Kevin Young Bureau of Program Operations Division of Utilization Analysis

Description: In the administration of the Medicare program, the Health Care Financing Administration (HCFA) is charged by Congress with the task of developing programs and procedures to identify potentially inappropriate medical utilization and with developing safeguards to ensure that Medicare beneficiaries are not provided with medically unnecessary or inappropriate care. HCFA must provide to Congress and the Office of Management and Budget estimates of a contractor's medical review effectiveness in saving Medicare program dollars. The existing method of assessing the effectiveness of medical review requires new methodologies to quantify the effect of specific medical review activities and to measure the potential offsets to savings. The study has three components:

- Develop new methodologies that would comprehensively assess the effectiveness of existing Medicare intermediary and carrier medical review activities on the Medicare program including offsets to savings.
- Pilot test the newly developed methodologies and modify these methodologies.
- Report on findings from the pilot test and recommend the most reliable and cost-effective methodologies for HCFA implementation.

Recommendations to the awardee on each component will be made by HCFA and a technical advisory panel.

Status: This project is in the final phase, pilot testing, and is scheduled to end early in fiscal year 1995.

94-117 **Development of Global Risk Assessment Models**

Project No.:	17-C-90433/9
Period:	September 1994–September 1995
Funding:	$ 505,694
Award:	Cooperative Agreement
Principal Investigator:	Mark Hornbrook
Awardee:	Kaiser Foundation Research Institute 1800 Harrison Street Oakland, CA 94612
HCFA Project Officer:	Melvin J. Ingber Division of Beneficiary Studies

Description: The goal of this project is to develop an implementable risk adjuster covering all age groups. It will be based on data from health maintenance organizations (HMO), such as Kaiser Northwest, Kaiser Ohio, Health Partners, and Group Health Cooperative of Puget Sound. Starting from classifications such as ambulatory care groups, ambulatory diagnosis groups, diagnostic cost groups, chronic disease scores and clinical-behavioral diagnosis groups, a new system will be developed based on diagnoses and demographics. The classification would reflect HMO practices and could be used to assess the expected costs of individuals or groups with respect to each other.

Status: This project is in the development phase.

94-101 **Development of a Risk Adjustment System under Health Reform: Lewin/VHI, Inc.**

Project No.:	500-92-0021DO05
Period:	July 1994–June 1996
Funding:	$ 1,028,822
Award:	Delivery Order in Master Contract
Principal Investigator:	Allen Dobson, Ph.D.
Awardee:	Lewin/VHI, Inc. (See page 213)
HCFA Project Officer:	Gerald F. Riley Division of Beneficiary Studies

Description: Under this project, two previously developed risk adjustment systems will be modified and combined. Payment amounts for capitated systems were developed originally for the Medicare population and are based primarily on diagnoses associated with inpatient hospital stays. Ambulatory care groups were developed from data for the population under 65 years of age and are based on diagnoses found in outpatient claims for physician services. These risk adjustment systems will be combined and calibrated on a data set representing several types of insurers: a large health maintenance organization; the Federal employee's health benefit program data from Blue Cross Blue Shield; and Medicaid data from the State of Washington. The project also will develop risk

adjusters based on demographic information and will incorporate reinsurance and flat payments for high-cost episodes in its risk adjustment system.

Status: The project is in the planning stage.

94-016 Development of a Risk Adjustment System under Health Reform: The Rand Corporation

Project No.:	500-92-0023DO09
Period:	July 1994–June 1996
Funding:	$ 733,133
Award:	Delivery Order in Master Contract
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The RAND Corporation (See page 214)
HCFA Project Officer:	Melvin J. Ingber Division of Beneficiary Studies

Description: This project will develop a risk assessment and risk adjustment system for the non-Medicare population. It proposes to combine a diagnosis-based system for grouping episodes of illness to determine a basic capitation level, prospective payment for particular episodes, and reinsurance as a risk reducing system. A modified diagnosis group severity system will be the basis for defining types of episodes. The system could be used to assess the expected costs of health plan enrollees and to adjust payments to the plans. A theoretical model of provider behavior is to be developed as a guide to structuring a risk adjustment and reinsurance scheme.

Status: The project is in its early stages.

93-046 Development and Testing of Risk Adjusters Using Medicare Inpatient and Ambulatory Data
(Formerly, Development of Risk-Adjustment Models)

Project No.:	500-92-0021DO02
Period:	June 1993–May 1995
Funding:	$ 499,911
Award:	Delivery Order in Master Contract
Principal Investigator:	Jonathan P. Weiner
Awardee:	Lewin/VHI, Inc. (See page 213)
HCFA Project Officer:	Melvin J. Ingber Division of Beneficiary Studies

Description: This project will continue the development of a patient-classification scheme to help determine capitated rates for Medicare health maintenance organization enrollees based on the expected medical costs of enrollees. The system, ambulatory care groups (ACG), uses diagnosis data from physician records to classify patients into diagnosis groups. The pattern of diagnosis groups determines classification in a cost group. Diagnostic data from inpatient stays and hospital outpatient visits will be incorporated into the revised model. The system can be used for risk assessment of enrollees in health plans and for risk adjustment of payments to the plans.

Status: Data development for this project has been completed. Incorporation of inpatient information has started.

94-100 Enrollment and Utilization Across Medicare Supplemental Plans

Project No.:	17-C-90328/1
Period:	September 1994–May 1996
Funding:	$ 193,096
Award:	Cooperative Agreement
Principal Investigator:	Rezaul Khandker, Ph.D.
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Judith A. Sangl, Sc.D Division of Long-Term Care Experimentation

Description: This study investigates variations in enrollment and utilization across Medicare supplemental plans to: identify patterns and determinants of enrollment in supplemental insurance policies; and describe the effects of these policies on the utilization of health care services by beneficiaries with differing characteristics and health status. There are three study questions: What factors account for beneficiary choice among the available options? How does utilization vary among those with and without supplemental policies, and those with supplemental policies of different types? and How does supplemental insurance affect beneficiary satisfaction with their health insurance coverage? The study uses data from: the Medicare Current Beneficiary Survey (1991-93); Medicare Part A and B records merged with survey respondents; and the area resource file.

Status: The project is in its design phase.

94-106 Evaluating Alternative Risk Adjusters for Medicare

Project No.:	17-C-90316/1
Period:	September 1994–September 1996
Funding:	$ 327,560
Award:	Cooperative Agreement
Principal Investigator:	Gregory C. Pope, Ph.D.
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Renee Mentnech Division of Beneficiary Studies

Description: This project will use a variety of health status measures (e.g., functional limitations, chronic conditions, and perceived health status) from the Medicare Current Beneficiary Survey (MCBS), along with the traditional adjusted average per capita cost factors to predict future expenditures for the purpose of risk adjustment. Alternative risk adjusters also will be evaluated. That is, the predictive accuracy of survey-based risk adjusters from the MCBS will be compared to claims-based risk adjusters that have been developed (e.g., diagnostic cost groups, ambulatory care groups, and payment amount for capitated systems). This project also will examine the stability of health status risk adjusters over time.

Status: This project has just been awarded and work will begin shortly.

89-033 Evaluation of the Arizona Health Care Cost-Containment System

Project No.:	500-89-0067
Period:	September 1989–September 1995
Funding:	$ 3,834,360
Award:	Contract
Principal Investigator:	Nelda McCall
Awardee:	Laguna Research Associates 455 Market Street, Suite 1190 San Francisco, CA 94105
HCFA Project Officer:	Ronald W. Lambert Division of Health Systems and Special Studies

Description: The awardee is evaluating the continuing operation of the Arizona Health Care Cost-Containment System (AHCCCS), with particular emphasis on the implementation and operation of the Arizona Long-Term Care System (ALTCS), a new component of AHCCCS, which began in December 1988. AHCCCS is a unique, State-sponsored capitation demonstration that provides public assistance medical care to residents of Arizona who are eligible for Aid to Families with Dependent Children and Supplemental Security Income cash payments. Major research questions to be investigated include:

- Does competitive bidding and selective contracting result in a lower per unit LTC service cost?
- How effective is the preadmission screening (PAS) instrument used by ALTCS in identifying individuals who are at risk of being institutionalized?
- Can home and community-based (HCB) services be substituted for long-term institutional care for individuals who pass PAS, and are those HCB services less expensive than institutional care?
- Does case management of LTC services result in lower cost and better coordination of care?
- What are the effects of capitating LTC services?
- Is the ALTCS more cost-effective than a comparable State's fee-for-service LTC program?

Status: This evaluation is beginning its sixth year. The first, second, and third implementation and operation reports and the first and third outcome reports have been received. According to these reports, ALTCS'use of HCB services appears to be cost effective for both the elderly and physically disabled and the mentally retarded/developmentally disabled populations. The Prepaid Medicaid Management Information System (PMMIS) development effort has been completed. PMMIS development and operational costs were considerably greater than originally anticipated, and many of the expected financial benefits have not been realized. However, many significant intangible benefits have been experienced, including the ready access it provides to critical program information. The results of the quality of care analysis indicate that ALTCS nursing home residents are more likely to experience a decubitus ulcer, a fever, or a catheter insertion than nursing home residents covered by New Mexico Medicaid, suggesting a lower quality of care for ALTCS nursing home residents than for those in New Mexico. However, the lack of pre-ALTCS data precludes an analysis of the improvements in quality since ALTCS began. The cost of the ALTCS program during its first 3 years was somewhat less than the cost of a traditional program in Arizona (6 percent in fiscal year {FY} 1990; 13 percent in FY 1991). The AHCCCS acute care program cost also continued to be less than the cost of a traditional fee-for-service program.

93-034 Evaluation of Global Budgeting Strategies

Project No.:	500-92-0020DO03
Period:	April 1993–June 1994
Funding:	$ 329,923
Award:	Delivery Order in Master Contract
Principal Investigator:	A. James Lee, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Payment and Economic Studies

Description: This project documents practical experience with full and partial global budgeting in the United States and abroad, and presents and assesses options for implementing health budget caps in the United States. The project collects information from selected health care systems about health resource allocation through budgeting.

Status: The final report, "Evaluation of Global Budgeting Strategies," has been received and is available from the National Technical Information Service, accession number PB94-203916. The report includes case studies of national systems (Germany, the Netherlands, Canada), a community-wide system (Rochester, New York), government-administered systems (the Military Health System, Veterans Administration, Arizona Health Care Cost Containment System) and managed care systems (Harvard Community Health Plan, Kaiser Permanente, Physician Health Services, PacifiCare). The report draws several lessons from domestic and foreign systems. Among them are:

- Both hard caps and softer targets can be used to constrain health expenditures.
- Effective global budget systems rely on meaningful indicators of aggregate demand as signals for total expenditures.
- Systems that involve negotiations with providers are more likely to reach an appropriate aggregate budget.
- Sectoral budgets, because of the inflexibility of substitution of resources among providers, eventually promote inefficiency in the delivery of health services.
- Efficient, flexible resource allocation requires that physicians be positioned in the budget structure so that they have authority and take responsibility for managing resources.

94-127 Evaluation of the Oregon Medicaid Demonstration

Project No.:	500-94-0056
Period:	October 1994–September 1999
Funding:	$ 3,239,374
Award:	Contract
Principal Investigator:	Margo L. Rosenbach, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Paul J. Boben, Ph.D. Division of Health Systems and Special Studies

Description: The objectives of the Oregon Medicaid Reform Demonstration are to increase the number of individuals with access to affordable health care services and to contain State and Federal expenditures for health care. Under the demonstration, Medicaid coverage is made available to all State residents with family incomes less than or equal to the Federal poverty level. Two distinct strategies are used to generate the program savings needed to support the expanded enrollee population. Program savings are generated by restructuring the Medicaid benefit package by establishing a prioritized list of conditions and related treatments (CT pairs), limiting coverage to a pre-established number of CT pairs, and expanding the use of managed care for the delivery of Medicaid services. The demonstration began operation on February 1, 1993, and is scheduled to run for 5 years. The objectives of this evaluation are to determine the impact of the demonstration on access to care, quality of care, enrollee satisfaction, and the cost of care, for both new enrollees and those previously enrolled in Medicaid. To the extent possible, the impact of the prioritized list and the increased use of managed care will be identified separately. Other areas of interest include the impact of the demonstration on the number of uninsured in the State, provider participation and satisfaction, and the number of private employers who offer health insurance as a fringe benefit. The evaluation study also will assess whether the concepts being tested in Oregon can be used in other States.

Status: An initial planning meeting was held to discuss the first year of the evaluation. Early priorities include the appointment and convening of the technical advisory panel, preparation of the baseline survey of enrollees, and the initial site visit to the State, which is scheduled tentatively for late November.

94-126 **Evaluation of the State Medicaid Reform Demonstrations**

Project No.:	500-94-0047
Period:	September 1994–September 1999
Funding:	$ 5,636,584
Award:	Contract
Principal Investigator:	Judith Wooldridge
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW., Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	James P. Hadley Division of Health Systems and Special Studies

Description: Under this contract, Mathematica will evaluate five State Medicaid reform demonstrations: Hawaii's Health QUEST, Rhode Island's RIteCare, and Tennessee's TennCare, with two other States added as their waivers are approved. The evaluator will conduct State-specific and cross-state analyses of demonstration impacts on utilization, insurance coverage, public and private expenditures, quality, access, and satisfaction. Analyses of all groups will, where possible, be stratified by age, income, geographic location, and other relevant demographic variables. Wherever possible, analyses of the impact of the demonstrations on vulnerable subpopulations, such as those with chronic physical or mental conditions, the homeless, and acquired immunodeficiency syndrome patients, will be performed. Data will come from site visit interviews with providers, advocacy groups, and State officials; participant surveys; State Medicaid Management Information Systems and encounter data; hospital discharge data; routine cost reports from the State and providers; vital records; and secondary data sources such as the area resource file and current population survey.

Status: The contract for the evaluation was signed on September 29, 1994. The first annual report is expected December 31, 1995, with subsequent annual reports expected in 1996, 1997, and 1998. The final report is due September 30, 1999.

92-012 **Examining the Medicaid Fiscal Crisis**

Project No.:	18-C-90028/1
Period:	February 1992–September 1994
Funding:	$ 347,403
Award:	Cooperative Agreement
Principal Investigator:	Jerry Cromwell, Ph.D.
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Cynthia G. Tudor, Ph.D. Office of Demonstrations and Evaluations

Description: Medicaid expenditures are rising annually and constitute an increasing share of State spending. This project attempted to understand the reasons for such growth. Specifically, this study sought to develop and test a model of a State's Medicaid program. The Study focused on the model's breadth and depth of coverage and payer generosity, including State variations in enrollment rates. The study also described how States finance their Medicaid programs.

Status: The results showed that the total number of Medicaid enrollees remained fairly constant between 1975 and 1989 and started to increase dramatically in 1990 as the economic growth rate declined and new Medicaid mandates were enacted. Some overall vertical taxpayer equity in Medicaid exists (i.e., a State's own burden rises with a State's own wealth), but there remains substantial disparity in spending across States at given levels of tax capacity. Low tax efforts and small Medicaid spending go together for 15 of 50 States, while high tax efforts and relatively large Medicaid programs are found in 15 more liberal, wealthier States. Finally, there appears to be a systematic relationship between State tax effort, which ultimately determines the size of a State's public sector, and the sources of revenue on which a State chooses to rely.

94-125 **Florida Health Security**

Project No.:	11-W-00025/4
Period:	September 1994–April 2000 (estimate)
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Tom Wallace
Awardee:	Florida's Agency for Health Care Administration The Atrium 325 John Cox Road, Suite 301 Tallahassee, FL 32303-4131
HCFA Project Officer:	Alisa Adamo Division of Health Systems and Special Studies

Description: The Florida Health Security (FHS) program will build on the State's managed competition model to test the extent to which Federal and State assistance will

allow employers to provide coverage to employees and their dependents in a voluntary market. FHS is a voluntary, employer-based, discounted premium program designed to provide access to private health insurance for uninsured, working Floridians. FHS will provide health insurance for 1.1 million uninsured Floridians with a gross income at or below 250 percent of the Federal poverty level. (Certain individuals such as Medicaid and Medicare eligibles and individuals who have been insured in the previous 12 months are ineligible for FHS.) The FHS program is distinctly separate from the State's traditional Medicaid program. The traditional Medicaid program will not be impacted by the FHS program; however, a series of reforms will be occurring in the State's traditional Medicaid program and these reforms should provide most of the financing for the FHS program. The reforms include mandating managed care for all traditional Medicaid eligibles and eliminating the Medically Needy program. Most medically needy individuals will be eligible for FHS; those that are not will be grandfathered into the traditional Medicaid program. Under FHS, health plans (indemnity and health maintenance organization) will be offered by accountable health partnerships and administered by a network of community health purchasing alliances established to implement Florida's overall managed competition strategy. The State will implement the program 90 days after the State legislature approves the project.

Status: The Federal waivers were awarded on September 15, 1994.

93-062 Hawaii Health QUEST

Project No.:	11-W-00001/9
Period:	July 1993–July 1999
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Winnie Odo
Awardee:	Hawaii Department of Human Services P.O. Box 339 Honolulu, HI 96809-0339
HCFA Project Officer:	Ronald W. Lambert Division of Health Systems and Special Studies

Description: This is a statewide project that will arrange for health care through capitated managed care plans. The project will create a purchasing pool of public clients and will extend the Medicaid eligibility income limits to 300 percent of the Federal poverty level. Medical, dental, and mental health services will be provided to those who are categorically eligible under Aid to Families with Dependent Children and to those currently receiving services under State public programs. The major features of the Health QUEST program are:

- Integration of the Medicaid program with State programs for the uninsured provides "seamless" access to care.
- Services are provided through fully capitated managed care plans.
- State is the purchasing cooperative for the pool of clients, and health plans are encouraged to bid for the pool.
- Benefits in the standard benefit package are consistent with the benefits offered by employers by State mandate.

Status: Hawaii Health QUEST was implemented on August 1, 1994. Approximately 105,000 beneficiaries are enrolled in five capitated health plans and two capitated dental plans. Mental health services will be provided to children under a capitated managed care approach through an interagency agreement with the Hawaii Department of Health.

91-042 Indexes for Adjusting Medicaid Eligibility and Matching Rates

Project No.:	99-C-98526/1
Period:	August 1991–February 1993
Funding:	$ 52,040
Award:	Cooperative Agreement
Principal Investigator:	Jerry F. Boren
Awardee:	Brandeis University Research Center (See page 204)
HCFA Project Officer:	Penelope L. Pine Division of Program Studies

Description: For this project, researchers evaluated the practicality of using various State costs-of-living indexes for adjusting national income eligibility requirements. They also evaluated measures of State fiscal capacity as a basis for modifying the formula for calculating the Federal medical assistance percentage.

Status: The final report, "Options for Reforming the Medicaid Matching Formula," accession number PB94-103553, is available from the National Technical Information Service. The analysis examines Medicaid's current matching formula and presents options for revising the formula. The matching formula determines a State's share for financing Medicaid. (A number of weaknesses in the current methodology are highlighted.) Suggested possible adjustments and additions to the formula are: improving the measurement of State fiscal

capacity; adjusting the measure of fiscal capacity for interstate cost-of-living differences; compensating for differences in the cost of health care across States; and incorporating measures of health care needs and non-health care needs, which place a disproportionate burden on some States relative to other States.

93-053 Issues Involved in Developing a Standardized Benefit Package

Project No.:	500-92-0024DO05
Period:	July 1993–March 1994
Funding:	$ 177,182
Award:	Delivery Order in Master Contract
Principal Investigator:	John Holahan, Ph.D.
Awardee:	The Urban Institute (See page 215)
HCFA Project Officer:	Gerald F. Riley Division of Beneficiary Studies

Description: The investigators will explore issues related to the development of a standardized benefit package and will prepare a report discussing those issues. The exploration of the issues will consist of these specific tasks:

- A literature review of previous work in the area.
- Discussions with government and academic leaders who have theoretical and practical experience with designing benefit packages.
- Analysis of employer-sponsored benefit package data collected by the U.S. Department of Labor.

Status: A report, "Issues involved in developing a standard benefit package," accession number PB95-103933, is available from the National Technical Information Service.

94-022 Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment: Health Economics Research, Inc.

Project No.:	500-92-0020DO10
Period:	September 1994–April 1995
Funding:	$ 118,353
Award:	Delivery Order in Master Contract
Principal Investigator:	Rezaul Khandker, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Jay Bae, Ph.D. Division of Beneficiary Studies

Description: The purposes of this project are to examine the effects of the current Federal drug payment policy (i.e., Medicaid rebate policy) and other related policies (e.g., formularies, prior authorization, drug utilization review) in the rapidly changing health care market environment, and to identify and analyze issues to consider in formulating efficient and equitable Federal drug payment policies for the reformed health care environment. The main difference between this project and the project by Health Economics Research, Inc., and the project awarded to KPMG Peat Marwick under the same solicitation is that this project attempts to analyze the effects of such issues within the theoretical framework of microeconomic models of the industry and policy instruments, while the KPMG Peat Marwick project is expected to produce conceptual analyses of various policy options.

Status: This project is in the early developmental stage.

94-021 Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment: KPMG Peat Marwick

Project No.:	500-93-0031DO02
Period:	October 1994–April 1995
Funding:	$ 128,228
Award:	Delivery Order in Master Contract
Principal Investigator:	David Gross
Awardee:	KPMG Peat Marwick (See page 212)
HCFA Project Officer:	Jay Bae, Ph.D. Division of Beneficiary Studies

Description: The purposes of this project are to examine the effects of the current Federal drug payment policy (i.e., Medicaid rebate policy) and other related policies (e.g., formularies, prior authorization, drug utilization review) in the rapidly changing health care market environment, and to identify and analyze issues to consider in formulating efficient and equitable Federal drug payment policies for the reformed health care environment. The main difference between this project by KPMG Peat Marwick and the project awarded to Health Economics Research, Inc. (HERI), under the same solicitation is that this project focuses more on conceptual analyses of various policy instruments, while the HERI project focuses more on quantitative microeconomic modeling of the industry and theoretical discussions.

Status: This project is in the early developmental stage.

94-128 **Kentucky Medicaid Access and Cost-Containment Demonstration Project**

Project No.:	11-W-00005/4
Period:	January 1994–December 1998
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Masten Childers II
Awardee:	Kentucky Department for Medicaid Services Cabinet for Human Resources Frankfort, KY 40621-0001
HCFA Project Officer:	Penelope L. Pine Division of Health Systems and Special Studies

Description: This demonstration is pursuant to the proposed Kentucky Health Care Reform Plan, which is intended to provide universal access to health care coverage in a managed care environment with strong emphasis on primary care and prevention, accompanied by specific measures such as global budgeting, private insurance reform, and ratesetting to achieve cost control in all sectors of the health care market. All eligibles will be enrolled in managed care plans similar to the State's Primary Care Case Management program or through alternative managed care plans. The benefit package to be provided to new Medicaid eligibles is the same as that currently given to categorically and medically needy Medicaid eligibles.

Status: In June, Kentucky held a special legislative session which passed a budget bill including language that prohibits operation of any waiver programs expanding Medicaid eligibility or services that were not implemented by January 1, 1994. As a result of this language, at this time, the State cannot implement the Kentucky Medicaid Access and Cost-Containment Demonstration Project.

IM-006 **Longevity and Medicare Expenses** (Formerly, Lifetime Medicare Costs by Time on Medicare)

Funding:	Intramural
HCFA Project Director:	James D. Lubitz Division of Beneficiary Studies

Description: Little is known about the relationship between longevity and lifetime Medicare costs. This study uses the Continuous Medicare History Sample, a longitudinal file covering years 1974 to 1990, to estimate Medicare payments for persons dying from 65 years of age to over 100 years of age. It simulates lifetime Medicare payments under various future longevity scenarios.

Status: A draft report has been completed and will be submitted for publication.

93-068 **Options for Federal Funding for State Costs under Health Care Reforms**

Project No.:	500-92-0024DO06
Period:	September 1993–January 1995
Funding:	$ 285,488
Award:	Delivery Order in Master Contract
Principal Investigator:	John Holahan, Ph.D.
Awardee:	The Urban Institute (See page 215)
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Payment and Economic Studies

Description: National health reform will have major financing roles for both Federal and State Governments. This study will analyze the options for determining both State contributions to a national health plan as well as the Federal contribution to State costs. The study has three components:

- Identify options for Federal and State financial sharing of costs of different components of the health system, model those efforts, and identify the winners and losers under each approach.
- Assess options in the phase-in of new financing arrangements and develop plans for transition to the new system.
- Report on potential problem areas, including State "gaming" and new approaches to adjust financing formulas for State and national economic cycles.

Recommendations to the awardee on each component will be made by the Health Care Financing Administration and a technical advisory panel.

Status: Work continues on all components of this project. The identification of options to be modeled has been hindered by lack of congressional consensus regarding the status of the Medicaid program under health care reform legislation. Three draft papers discussing the implementations of current legislative proposals were received.

93-038 **Oregon Reform Demonstration**

Project No.:	11-P-90160/0
Period:	April 1993–January 1999

Funding:	Waiver only
Award:	Grant
Principal Investigator:	Lynn Read
Awardee:	Oregon Department of Human Resources 500 Summer Street, NE. Salem, OR 97310
HCFA Project Officer:	Ronald W. Deacon Division of Health Systems and Special Studies

Description: The Oregon Reform Demonstration is an innovative program of private insurance reform, employer coverage, managed care, and restructured Medicaid benefits for both the Medicaid-eligible and the uninsured populations. The demonstration is scheduled to operate between February 1, 1994, and January 31, 1999. The demonstration will extend Medicaid eligibility for Oregonians whose income is below the Federal poverty level, regardless of age, sex, and family status (excluding the aged, blind and disabled, and children in foster care). Since the number of persons eligible for benefits will increase substantially, Oregon will implement two mechanisms for containing costs: prioritization of condition-specific treatments and procedures that will be included in the Medicaid benefit package; and managed care initiatives to enhance coordination of care and provide incentives for controlling costs. The initial benefit package does not affect coverage currently available for mental health, chemical dependency, and long-term care services. Mental health and chemical dependence services will be incorporated into a revised benefit package and a revised priority list at a later date, when the demonstration is to be extended to the excluded populations. Nursing facilities and home- and community-based services will not be affected by the demonstration.

Status: The State began enrollment in February 1994. Approximately 183,000 currently Medicaid eligible and 72,000 previously uninsured individuals have enrolled in the Oregon Health Plan. The delivery system consists of 16 fully capitated health plans, 4 partially capitated physician care organizations, and 5 dental care organizations. There are 440 primary care case managers also under contract to provide care in 8 counties without sufficient prepaid health plans. In the other counties where a sufficient number of plans have contracted, participant must select a plan or be assigned to one. Under an expansion plan expected to begin by January 1995, another 87,000 aged and disabled Medicaid eligibles will enroll in the Oregon Health Plan. Mental health and chemical dependency services also will be included under the plan in January 1995.

94-104 Rhode Island RIte Care

Project No.:	11-W-00004/1
Period:	April 1994–March 1999
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Robert J. Fallon
Awardee:	State of Rhode Island Department of Human Services 600 New London Avenue Cranston, RI 02920
HCFA Project Officer:	Deborah C. Van Hoven Division of Health Systems and Special Studies

Description: This statewide initiative, approved November 1993, seeks to increase access to, and delivery of, primary and preventive health care services for all Aid to Families with Dependent Children (AFDC) recipients (65,000) and to extend coverage to approximately 10,000 pregnant women and children under 6 years of age with family incomes up to 250 percent of the Federal poverty level (FPL). RIte Care eligibles will be required to enroll in prepaid health plans contracted with the State to provide comprehensive health services. Prepaid health plans will offer medical, dental, and mental health benefits. Long-term care services will not be provided through the plans. Plans will be required to offer participants a package of enhanced services to assist in overcoming the nonfinancial barriers to care, including home visits, nutrition counseling, child birth education, parenting skills education, and smoking cessation. Pregnant women enrolled in RIte Care who lose eligibility 60 days post-partum will be offered the opportunity to enroll in an extended family planning program for a 2-year period. RIte Care will include a cost-sharing component. Individuals with incomes between 185 and 250 percent of the FPL (new eligibles) will be subject to cost-sharing requirements, either through premiums or co-payment arrangements. Individuals with incomes less than 185 percent of the FPL will not be subject to any cost-sharing requirements.

Status: Enrollment in this program began August 1, 1994.

94-122 Risk-Adjusted Payment Models for the Non-Elderly

Project No.:	18-C-90462/1
Period:	September 1994–September 1997
Funding:	$ 802,651

Award:	Cooperative Agreement
Principal Investigator:	Arlene Ash
Awardee:	Boston University 80 East Concord Street Boston, MA 02118
HCFA Project Officer:	Gerald F. Riley Division of Beneficiary Studies

Description: This project will develop a diagnostic cost group (DCG) model for the population under 65 years of age that would incorporate diagnoses from both inpatient and ambulatory encounters. A similar model is being developed for the Medicare population under another project. DCGs use diagnoses to classify enrollees into groups with similar expected costs in the subsequent year. The project will use data from several sources: CalPers (the five largest participating plans), Medicaid Statistical Information System (three States), MEDSTAT, and data from Massachusetts State employees and dependents. The data cover 1991–94 and include approximately 2 million covered lives.

Status: The project is in the early developmental stage.

94-124 Risk Adjustment of Payment for Mental Health and Substance Abuse

Project No.:	18-C-90314/1
Period:	September 1994–September 1996
Funding:	$ 977,300
Award:	Cooperative Agreement
Principal Investigator:	Richard Gabriel Frank, Ph.D.
Awardee:	Harvard Medical School 25 Shattuck Street Boston, MA 02115
HCFA Project Officer:	Jay Bae, Ph.D. Division of Beneficiary Studies

Description: This risk adjustment research project attempts to study the issues that arise from providing mental health and substance abuse care coverage under a capitation system. There are three main objectives. First is to test the ability of three risk classification systems (ambulatory care groups, diagnostic costs groups, and payment amounts for capitated systems) to explain the variation in mental health and substance abuse (MH/SA) costs. The project will modify the existing systems to improve their ability to explain the variation in MH/SA costs. Second is to collect information on private sector cost-sharing arrangements for "carve-out" providers of MH/SA benefits. Using the information, profits and losses of different arrangements will be compared. Third is to develop a simulation model that is based on the risk classification systems and the private sector cost-sharing arrangements. The project will evaluate the predictive accuracy of the hybrid simulation model for premium setting purposes.

Status: This project is in the early developmental stage.

92-011 Sources of Medicaid Expenditure Growth: A Comprehensive Analysis

Project No.:	18-C-90072/32
Period:	February 1992–April 1994
Funding:	$ 310,131
Award:	Cooperative Agreement
Principal Investigator:	John Holahan, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Cynthia G. Tudor, Ph.D. Office of Demonstrations and Evaluations

Description: This project will use a variety of approaches to examine the recent rapid growth in Medicaid expenditures. One approach will be to specify and estimate Medicaid expenditure models, including growth in Medicaid spending for the aged, disabled, and pregnant women and children. The modeling will attempt to analyze the effects of general economic conditions, the rise in health care costs, and the impact of various Federal mandates, while controlling for other determinants of Medicaid spending. Another approach will examine how Medicaid enrollment per person in poverty and Medicaid benefits per enrollee have changed between 1985 and 1990.

Status: Analyses confirm that enrollment is positively and significantly related to Medicaid expenditures. These analyses also suggest that other factors (e.g., Federal Medicaid policy, economic factors, provider tax and donation programs, and tax price and capacity) are statistically significant determinants of growth in Medicaid spending. The results suggest that dramatic rates of expenditure growth in Medicaid are not expected to continue. The impact of some programs on spending (e.g., provider taxes) will subside, while other factors (e.g., eligibility expansions affecting low-income children and acquired immunodeficiency syndrome cases) may continue to affect expenditure growth.

93-032 **State Legislative Initiatives**

Project No.:	500-92-0023DO05
Period:	March 1993–October 1994
Funding:	$ 288,222
Award:	Delivery Order in Master Contract
Principal Investigator:	Peter Jacobson
Awardee:	The RAND Corporation (See page 214)
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Payment and Economic Studies

Description: This project has two phases. During the first phase, RAND identifies States that have implemented or enacted legislation to contain health care costs during the past few years. During the second phase, RAND conducts an indepth analysis of six innovative State programs for controlling inpatient and/or outpatient costs.

Status: The final report, "State Health Care Reform Initiatives: Progress and Promise," for both phases of the project has been received and reviewed. The report contains individual State profiles of legislation enacted between 1988 and 1993. These profiles include a complete description of legislative provisions. The report also includes an indepth analysis of six State programs: New York, Maryland, California, Washington, Vermont, and Minnesota. The investigators draw several conclusions about the success of cost-containment initiatives. In particular:

- Regulatory approaches have been quite successful in containing unit costs, but their success in containing per capita costs is less dramatic and more uneven.
- Success in containing costs for one payer or group of payers may not transfer to the broader system, and in fact may increase costs elsewhere in the system because of cost-shifting.
- Success in containing costs is not always accompanied by success in meeting other objectives, such as increased access for uninsured populations.
- Success in restraining system-wide costs, without imperiling access, requires that cost containment be embedded in a more comprehensive reform plan.

Copies of the report (PM-311-HCFA) are available from RAND, 1700 Main Street, Post Office Box 2138, Santa Monica, California 90407-2138.

93-039 **State Primer on All-Payer Systems for Health Care Services** (Formerly, Assessing the Viability of All-Payer Systems for Health Care Services: Health Economics Research, Inc.)

Project No.:	500-92-0020DO04
Period:	May 1993–December 1994
Funding:	$ 337,542
Award:	Delivery Order in Master Contract
Principal Investigator:	Jerry Cromwell, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment and Economic Studies

Description: Interest in health care reform has spread along multiple dimensions. In addition to national initiatives, there are State initiatives; in addition to managed care initiatives, there are single-payer, multiple-payer, and all-payer ratesetting initiatives. The purpose of this project is to produce a primer to inform States on the issues that would have to be addressed to design and implement an all-payer ratesetting system for physician and hospital services.

Status: The Health Care Financing Administration has received drafts of many of the chapters of the primer.

94-030 **State Rural Health Network Reform Initiative: Assisting Washington Rural Communities Transition to Health Care Reform**

Project No.:	50-P-90262/0
Period:	August 1994–July 1997
Funding:	$ 350,000
Award:	Grant
Principal Investigator:	Verne Gibbs
Awardee:	Washington State Department of Health Office of Community and Rural Health P.O. Box 47834 Olympia, WA 98504-7834
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation

Description: The State Rural Health Network Reform Initiative is a Health Care Financing Administration (HCFA) program to provide grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of

comprehensive statewide health reform. HCFA awarded $1,616,844 to Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents. The six awardees proposed projects that came closest to addressing HCFA's primary policy interests for this program, including: a clear understanding of the characteristics of the State's rural communities and their health care needs; development of the necessary infrastructure to support viable long-term solutions for rural communities; integration of the rural reform project with broader comprehensive health reform initiatives within the State; an explanation of the financing of the plan and how it addresses care and coverage for the uninsured; an emphasis on public health and primary care and the integration of these activities with other services; and a description of the steps toward program implementation. The 6 awardees were chosen from 24 States that submitted applications for this initiative.

Status: This project is in the early developmental stage.

94-025 **State Rural Health Network Reform Initiative: Financing Models for Florida's Rural Health Networks**

Project No.:	50-P-90257/4
Period:	August 1994–July 1997
Funding:	$ 300,000
Award:	Grant
Principal Investigator:	Janet P. Barber, Ph.D.
Awardee:	Agency for Health Care Administration Office of Health Policy 325 John Knox Road, The Atrium Suite 301 Tallahassee, FL 32303
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation

Description: The State Rural Health Network Reform Initiative is a Health Care Financing Administration (HCFA) program to provide grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. HCFA awarded $1,616,844 to Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents. The six awardees proposed projects that came closest to addressing HCFA's primary policy interests for this program, including: a clear understanding of the characteristics of the State's rural communities and their health care needs; development of the necessary infrastructure to support viable long-term solutions for rural communities; integration of the rural reform project with broader comprehensive health reform initiatives within the State; an explanation of the financing of the plan and how it addresses care and coverage for the uninsured; an emphasis on public health and primary care and the integration of these activities with other services; and a description of the steps toward program implementation. The 6 awardees were chosen from 24 States that submitted applications for this initiative.

Status: This project is in the early developmental stage.

94-026 **State Rural Health Network Reform Initiative: Minnesota Rural Health Network Reform Initiative**

Project No.:	50-P-90279/5
Period:	August 1994–July 1997
Funding:	$ 325,000
Award:	Grant
Principal Investigator:	Chari Konerza
Awardee:	Minnesota Department of Health Office of Rural Health 717 Delaware Street Southeast P.O. Box 9441 Minneapolis, MN 55440-9441
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation

Description: The State Rural Health Network Reform Initiative is a Health Care Financing Administration (HCFA) program to provide grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. HCFA awarded $1,616,844 to Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents. The six awardees proposed projects that came closest to addressing HCFA's primary policy interests for this program, including: a clear understanding of the characteristics of the State's rural communities and their health care needs; development of the necessary infrastructure to support viable long-term solutions for rural communities; integration of the rural reform project

with broader comprehensive health reform initiatives within the State; an explanation of the financing of the plan and how it addresses care and coverage for the uninsured; an emphasis on public health and primary care and the integration of these activities with other services; and a description of the steps toward program implementation. The 6 awardees were chosen from 24 States that submitted applications for this initiative.

Status: This project is in the early developmental stage.

94-027 State Rural Health Network Reform Initiative: Mississippi Rural Health Network Reform Initiative

Project No.:	50-P-90270/4
Period:	August 1994–July 1997
Funding:	$ 240,000
Award:	Grant
Principal Investigator:	Helen Wetherbee
Awardee:	Mississippi Division of Medicaid 239 North Lamar, Suite 801 Jackson, MS 39211
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation

Description: The State Rural Health Network Reform Initiative is a Health Care Financing Administration (HCFA) program to provide grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. HCFA awarded $1,616,844 to Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents. The six awardees proposed projects that came closest to addressing HCFA's primary policy interests for this program, including: a clear understanding of the characteristics of the State's rural communities and their health care needs; development of the necessary infrastructure to support viable long-term solutions for rural communities; integration of the rural reform project with broader comprehensive health reform initiatives within the State; an explanation of the financing of the plan and how it addresses care and coverage for the uninsured; an emphasis on public health and primary care and the integration of these activities with other services; and a description of the steps toward program implementation. The 6 awardees were chosen from 24 States that submitted applications for this initiative.

Status: This project is in the early developmental stage.

94-028 State Rural Health Network Reform Initiative: Nebraska State Strategy for Building Rural Health Networks

Project No.:	50-P-90260/7
Period:	August 1994–July 1997
Funding:	$ 228,880
Award:	Grant
Principal Investigator:	David W. Palm, Ph.D.
Awardee:	Nebraska Department of Health Division of Health Policy and Planning 301 Centennial Mall South P.O. Box 95007 Lincoln, NE 68509-5007
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation

Description: The State Rural Health Network Reform Initiative is a Health Care Financing Administration (HCFA) program to provide grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. HCFA awarded $1,616,844 to Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents. The six awardees proposed projects that came closest to addressing HCFA's primary policy interests for this program, including: a clear understanding of the characteristics of the State's rural communities and their health care needs; development of the necessary infrastructure to support viable long-term solutions for rural communities; integration of the rural reform project with broader comprehensive health reform initiatives within the State; an explanation of the financing of the plan and how it addresses care and coverage for the uninsured; an emphasis on public health and primary care and the integration of these activities with other services; and a description of the steps toward program implementation. The 6 awardees were chosen from 24 States that submitted applications for this initiative.

Status: This project is in the early developmental stage.

94-029 **State Rural Health Network Reform Initiative: North Carolina Rural Health Network Reform Initiative**

Project No.:	50-P-90277/4
Period:	August 1994–July 1997
Funding:	$ 172,964
Award:	Grant
Principal Investigator:	James D. Bernstein
Awardee:	North Carolina Department of Human Resources Office of Rural Health and Resource Development 311 Ashe Avenue Raleigh, NC 27606
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation

Description: The State Rural Health Network Reform Initiative is a Health Care Financing Administration (HCFA) program to provide grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. HCFA awarded $1,616,844 to Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents. The six awardees proposed projects that came closest to addressing HCFA's primary policy interests for this program, including: a clear understanding of the characteristics of the State's rural communities and their health care needs; development of the necessary infrastructure to support viable long-term solutions for rural communities; integration of the rural reform project with broader comprehensive health reform initiatives within the State; an explanation of the financing of the plan and how it addresses care and coverage for the uninsured; an emphasis on public health and primary care and the integration of these activities with other services; and a description of the steps toward program implementation. The 6 awardees were chosen from 24 States that submitted applications for this initiative.

Status: This project is in the early developmental stage.

93-072 **Study of State Health Care Reform Initiatives**

Project No.:	500-92-0033DO03
Period:	September 1993–September 1995
Funding:	$ 548,572
Award:	Delivery Order in Master Contract
Principal Investigator:	James Lubalin
Awardee:	Research Triangle Institute (See page 205)
HCFA Project Officer:	David W. Walsh Division of Health Systems and Special Studies

Description: The purpose of this contract is to assist the Health Care Financing Administration's Office of Research and Demonstrations, and States, to develop and implement Medicaid program innovations and/or State health system reforms. The contract has three main objectives. First, to document the progress of States that have begun reform efforts by creating a library of information that can be updated as the implementation of reform occurs. Second, to facilitate the streamlining of the section 1115 demonstration waiver process by revising and simplifying the guidelines for project proposals, waiver cost estimates, and evaluation designs. Third, for the awardee to provide technical assistance to States, helping them through the development of demonstration proposals, evaluation designs, and issue papers.

Status: The contract was awarded in September 1993 to Research Triangle Institute. Subcontractors include the National Academy for State Health Policy, Indiana University, and Health Economics Research, Inc. The awardee is in the second year of operations.

94-080 **Tennessee TennCare**

Project No.:	11-W-00002/4
Period:	January 1994–December 1998
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Manny Martins
Awardee:	Tennessee Department of Health TennCare Bureau 344 Cordell Hull Building Nashville, TN 37247-0101
HCFA Project Officer:	Rose M. Hatten Division of Health Systems and Special Studies

Description: TennCare is a statewide program to provide health care benefits to Medicaid beneficiaries, uninsured State residents and those whose medical conditions make them uninsurable. Enrollment will be capped at 1,400,000. If the cap is reached, those in mandatory Medicaid coverage groups and the uninsurables will

continue to be enrolled, while the currently uninsured group enrollment will be limited. All enrollees are served in capitated managed care plans that are either health maintenance organizations or preferred provider organizations.

Status: The program began on January 1, 1994. Current enrollment is about 1.1 million. About 350,000 of these enrollees are in the uninsured and uninsurable groups. The State is planning another open enrollment period to bring enrollment up to the maximum of 1,400,000 people.

93-045 Update and Revision of the Continuous Update Diagnostic Cost Group Model

Project No.:	500-92-0020DO06
Period:	June 1993–May 1995
Funding:	$ 589,692
Award:	Delivery Order in Master Contract
Principal Investigator:	Randall Ellis
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Melvin J. Ingber Division of Beneficiary Studies

Description: This project is to continue the development of a patient classification scheme to help determine capitated rates for Medicare health maintenance organization enrollees based on expected medical costs of enrollees. The system, diagnostic cost groups (DCG), uses diagnosis data from inpatient records to classify patients by diagnoses and by characteristics of diagnoses, into cost groups. An annually updated model and a monthly updated model will be estimated. Information on diagnoses from hospital outpatient and physician encounters also will be integrated into the revised model. The system can be used for risk assessment of enrollees in health plans and for risk adjustment of payments to the plans.

Status: This project has completed data development and has done a preliminary study of the formal validity and consistency of diagnosis coding on claims. Reconsideration of the composition of DCG groups has started.

93-015 Use of Medicare Hospital Payment Methodologies by Medicaid Programs and Private Payers

Project No.:	500-92-0023DO04
Period:	February 1993–November 1993
Funding:	$ 142,122
Award:	Delivery Order in Master Contract
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The RAND Corporation (See page 214)
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Payment and Economic Studies

Description: This project has two purposes. The first is to identify the extent to which Medicaid programs, Blue Cross programs, managed care programs, commercial insurance programs, and self-insured employers use diagnosis-related groups (DRG). The second is to determine how the DRG patient classification system has been modified to accommodate the needs of other payers.

Status: The final report, "Use of DRGs by Non-Medicare Payers," is available from the National Technical Information Service, accession number PB94-176518. The investigators report widespread use of Medicare hospital payment methodologies by other governmental and private payers including two-thirds of Blue Cross Blue Shield Association Plans that use DRGs for at least one of their hospital insurance products and 21 States that use a DRG-like system for their Medicaid program. Rather than just adopting the Medicare weights and payment rates, DRG users for the non-Medicare population have developed widely varying diagnosis-related, per discharge, prospective payment systems. No single approach is dominant. What has emerged appears to be a very flexible payment system in which the only constant is the use of DRGs as a measure of output.

93-014 Use of Medicare Physician Payment Methodologies and Cost-Containment Strategies by Medicaid Programs and Private Payers

Project No.:	500-92-0020DO02
Period:	February 1993–December 1993
Funding:	$ 88,174
Award:	Delivery Order in Master Contract
Principal Investigator:	Lauren A. McCormack
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment and Economic Studies

Description: Under the Omnibus Budget Reconciliation Act of 1992 (Public Law 101-239), Congress legislated

the Medicare fee schedule (MFS) and Medicare volume performance standards. Two of the goals of these fundamental changes in the Medicare physician payment system were to improve equity and to contain the growth in Medicare physician expenditures that occurred in the 1980s. The purpose of this delivery order was to identify other parties who use, or are planning to use, the MFS or modifications of the MFS and cost-containment strategies and to determine the specifics of the various systems in these different environments. In summary, the report shows that there has been substantial diffusion of the resource-based relative value scale methodology that underlies the MFS, although the specific Medicare payment rules have not always been followed.

Status: This project has been completed. The final report, "Use of Medicare Payment Methodologies and Cost Containment Strategies by Medicaid Programs and Private Payers," is available from the National Technical Information Service, accession number PB94-19573.

Managed Care Systems

88-001 Amalgamated Medicare Insured Group

Project No.:	95-C-99171/2
Period:	October 1987–July 1995
Funding:	$ 333,744
Award:	Cooperative Agreement
Principal Investigator:	Richard Burker
Awardee:	Amalgamated Life Insurance Company 770 Broadway New York, NY 10003
HCFA Project Officer:	Ronald W. Deacon, Ph.D. Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The Amalgamated Medicare Insured Group (AMIG) is being developed by the Amalgamated Life Insurance Company (ALICO), administrators of trust funds for the Amalgamated Clothing and Textile Workers Union. The AMIG project will unify all aspects of program administration, including Medicare Parts A and B and Medicare supplemental benefits under the auspices of ALICO. Funding will be provided through a capitated rate paid by the Health Care Financing Administration, employer contributions, and enrollee premiums. By using managed health care systems and provider negotiation leverage resulting from a large retiree population, the AMIG is expected to reduce the cost to all payers.

Status: ALICO is proceeding to develop the specific elements of AMIG implementation. AMIG plans to begin the project in Philadelphia, Pennsylvania, in June 1995, where enrollment will be offered to approximately 8,000 retirees and spouses residing in the area. AMIG anticipates that enrollment will reach 1,000 within the first year of operation, reaching 3,500 by the end of the demonstration. If the concept proves successful, ALICO expects to add other sites to the demonstration. Possible sites are New York City, New York, and Baltimore, Maryland.

92-062 Case Management of Elderly at Risk for Acute Hospitalization

Project No.:	95-C-90165/5
Period:	September 1992–September 1995
Funding:	$ 131,076
Award:	Cooperative Agreement
Principal Investigator:	Larry Salwin
Awardee:	Providence Hospital 16001 West Nine Mile Road Southfield, MI 48045
HCFA Project Officer:	David W. Walsh Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The demonstration is designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. Providence Hospital will provide case management services to patients with a number of diagnoses associated with high rates of hospitalization.

Status: Providence began enrolling patients in November 1993. As of September 1994, it had enrolled 268 beneficiaries in the demonstration.

92-008 **Coverage Denial Disputes between Medicare Beneficiaries and Health Maintenance Organizations** (Formerly, A Study of Disputes between Medicare Beneficiaries and Health Maintenance Organizations, as Contained in Redeterminations of Health Maintenance Organization Claims/Coverage Denials)

Project No.:	17-C-90070/2
Period:	February 1992–February 1993
Funding:	$ 104,317
Award:	Cooperative Agreement
Principal Investigator:	David A. Richardson
Awardee:	Network Design Group, Inc. 1000 Pittsford-Victor Road Pittsford, NY 14534
HCFA Project Officer:	Alma B. McMillan Division of Beneficiary Studies

Description: The objective of this 1-year project, which began in February 1992, was to understand the reasons for disputes between Medicare beneficiaries and health maintenance organizations. To accomplish this objective, a sample of 750 completed cases in 1991, drawn from an existing data base of 1,731 formal disputes, was studied regarding claim and benefit coverage which arose in calendar year 1990. The framework for this analysis was developed by Network Design Group, Inc., Pittsford, New York, and consists of the identification of various attributes or characteristics present or absent in the file cases. The analysis produced an identification of "prototype" claim coverage dispute cases and a determination of the relative frequency of the various prototypes.

Status: This project has been completed. The final report, "Study of Coverage, Claims Denials, Appeals, Health Maintenance Organization," accession number PB94-118090, is available from the National Technical Information Service. Some study highlights include:

- From a sample of 747 reconsideration cases in the 1991 file, 10 percent of the disputes occurred within the first 90 days of enrollment and one-third within the first year.
- Nearly 60 percent of the cases involved disputes over the need for emergency services and the related "urgent" out-of-plan service area services. Researchers conclude that current definitions of "emergency" and "urgent" care are too complex for the average enrollee to comprehend and should be modified.
- The mean disputed dollar amount was about $2,500; the plan denials were upheld in nearly three-fourths of the cases and overturned in about one-fourth of the cases.
- Researchers recommend that "Limits of Liability" provisions that protect fee-for-service Medicare beneficiaries should be explicitly extended, with appropriate modification, to the health maintenance organization and competitive medical plans program.

92-060 **Demonstration Project to Case Manage Medicare Beneficiaries with Catastrophic and Chronic Conditions Residing in the State of Indiana**

Project No.:	95-C-90163/5
Period:	September 1992–September 1995
Funding:	$ 343,997
Award:	Cooperative Agreement
Principal Investigator:	Mary Jane Teirumniks
Awardee:	AdminaStar Solutions 9525 Delegates Row Indianapolis, IN 46240
HCFA Project Officer:	David W. Walsh Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The demonstration is designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. AdminaStar will provide case management services to patients with congestive heart failure.

Status: The enrollment of beneficiaries by AdminaStar took place during October and November 1993. The delivery of case management services to 1,100 beneficiaries began in December of 1993.

85-002 **Determination of Health Maintenance Organization Capitation Rates for Medicare Beneficiaries**

Project No.:	17-C-98804/9
Period:	September 1985–August 1989
Funding:	$ 1,046,935
Award:	Cooperative Agreement
Principal Investigator:	Mark Hornbrook
Awardee:	Kaiser Foundation Research Institute 3505 Broadway, Suite 1112 Oakland, CA 94611
HCFA Project Officer:	Gerald F. Riley Division of Beneficiary Studies

Description: The purposes of this project were to investigate the issue of biased selection in health maintenance organizations (HMO) and the problem of developing a risk-adjustment methodology for HMO payments by using internal data from the Kaiser Foundation Research Institute and data from the Bureau of Data Management and Strategy's Medicare Statistical System. The investigator was to:

- Predict health care costs for groups of stayers and switchers in the fee-for-service sector and an HMO (Kaiser Permanente) and estimate the degree of selection bias, if any, among HMO enrollees.
- Simulate Medicare capitation rates for an HMO using alternative risk-adjustment methods and compare these rates with the current adjusted average per capita cost (AAPCC) rate.
- Develop and test a risk-adjustment methodology employing cause-specific mortality and hospital morbidity for predicting future aggregate use of medical care services by Medicare beneficiaries enrolled in an HMO.
- Examine the implications of a separate reinsurance program for case-specific expenses above a specified level of alternative risk-adjusted capitation methods.
- Develop a risk-adjustment methodology by using ambulatory morbidity and self-perceived health status for predicting future aggregate use of medical care services by Medicare beneficiaries enrolled in an HMO.

Status: The following articles have been published:

- Hornbrook, M.C., Bennett, M.D., and Greenlick, M.R.: Adjusting the AAPCC for selectivity and selection bias under Medicare risk contracts. *Advances in Health Economics and Health Services Research* 10:111–149. JAI Press, Inc., 1989.
- Hornbrook, M.C., Greenlick, M.R., and Bennett, M.D.: Analytic perspective on data needs of health maintenance organizations. *Health Care Financing Review*. 1986 Annual Supplement, pp. 89-94. HCFA Pub. No. 03225. Office of Research and Demonstrations, Health Care Financing Administration. Washington, D.C. U.S. Government Printing Office, Dec. 1986.

The final report, "Determination of Capitation Payment Rates for Medicare HMO Beneficiaries," was received in August 1993. The report is available from the National Technical Information Service. For the full report, the accession number is PB94-101557; for the executive summary only, the accession number is PB94-109774.

92-013 Effect of Market Structure on Health Maintenance Organization Financial Performance

Project No.:	17-C-90055/3
Period:	February 1992–February 1994
Funding:	$ 171,860
Award:	Cooperative Agreement
Principal Investigator:	Douglas Wholey
Awardee:	Carnegie Mellon University 5000 Forbes Avenue Pittsburgh, PA 15213
HCFA Project Officer:	Gerald F. Riley Division of Beneficiary Studies

Description: The health maintenance organization (HMO) industry has expanded substantially over the past 10 years. This has led to substantially more competitive local HMO markets and a significant change in HMO demographics, with independent practice associations now the most prevalent HMO type. A correlate of these competitive changes is the increasingly restrictive State financial regulations. Research on HMO premiums and costs has not focused on the effects of these substantially different environments, thus little is known about the effects of market structure and State regulations on HMO premiums and costs. The purposes of this study are to: determine if competition among HMOs can result in beneficial effects for health care consumers through lower premiums and costs; estimate the financial effects of some specific State regulations on premiums and costs; and estimate the impact of competition and regulation on the marginal costs of providing health care to individuals under and over 65 years of age. The investigators will examine these questions for all HMOs operating during the period of 1988 to 1991 using data from financial statements filed by HMOs with State regulators and using measures of market structure developed in previous research.

Status: Two draft reports, "The Effect of Market Structure on HMO Premiums" and "Scale and Scope Economies among Health Maintenance Organizations," are under review.

93-075 Evaluation of the Cost of Health Maintenance Organizations and Health Care Prepayment Plans

Project No.:	500-92-0011DO03
Period:	September 1993–September 1995
Funding:	$ 538,869
Award:	Delivery Order in Master Contract
Principal Investigator:	Randall S. Brown, Ph.D.

Awardee:	Mathematica Policy Research, Inc.
	(See page 208)
HCFA Project Officer:	Ronald W. Lambert Division of Health Systems and Special Studies

Description: The awardee will evaluate the cost effectiveness of health maintenance organizations (HMO) and health care prepayment plans (HCPP) compared to fee-for-service and risk HMOs. A separate assessment of organizations that have recently converted from the risk option to either of these options will be conducted. The main question for this assessment is whether the Health Care Financing Administration would have saved or lost money had these organizations remained risk contractors. A case study of HCPPs will be conducted to determine the operational characteristics of the various types of HCPPs. The evaluator will examine how HCPPs coordinate the delivery of health services, given that it is not subject to the same regulatory requirements as risk or cost contractors.

Status: The case study of HCPPs has been conducted. The results will be included in the first year report which is expected in October 1994.

92-024 Evaluation of the Maryland Access to Care Demonstration: Managed Care for Medicaid Recipients

Project No.:	18-C-99142/3
Period:	February 1992–February 1995
Funding:	$ 225,275
Award:	Cooperative Agreement
Principal Investigator:	Julie A. Schoenman, Ph.D.
Awardee:	The People-to-People Health Foundation, Inc. Center for Health Affairs 7500 Old Georgetown Road, Suite 600 Bethesda, MD 20814-6133
HCFA Project Officer:	Paul J. Boben, Ph.D. Division of Health Systems and Special Studies

Description: The awardee will evaluate the Maryland Access to Care (MAC) demonstration, which became operational in December 1991, and had nearly 110,000 Medicaid recipients enrolled as of April 1992. The demonstration will eventually cover about two-thirds of all Medicaid recipients. The targeted population will be Aid to Families with Dependent Children recipients, Supplemental Security Income recipients, and Sixth Omnibus Budget Reconciliation Act eligible children. The MAC program is mandatory for recipients in the MAC eligible categories. The program matches MAC recipients with a primary medical provider (PMP) who acts as the recipient's gatekeeper to the health care system. These PMPs continue under standard fee-for-service reimbursement systems but, to encourage their participation, Medicaid fees for primary care services have been increased by an average of 50 percent. Specialists are reimbursed for nonemergency specialty care provided to MAC patients only if these services are referred by the patient's PMPs. The evaluation will employ a pre/post-test comparison and a post-test description of program operations. The data to be used will primarily be Medicaid enrollment and claims files and provider surveys.

Status: Baseline (3 years of pre-demonstration) and first year demonstration data have been obtained for the State, and some preliminary analyses have been performed. These results were reported in the Preliminary Draft Interim Report, which was received by the Health Care Financing Administration in May 1994. A final draft of this report is expected shortly. The survey of providers has been administered, and analysis of these data is proceeding. Last spring, subcontractor JSI Research and Training Institute, Inc., conducted site visits to MAC participating providers, discussing various issues surrounding the implementation and operation of MAC. Future work includes obtaining and analyzing claims data from the second demonstration year, fielding the second round of the provider survey, and conducting a fourth site visit.

93-073 Evaluation of Medicaid-Managed Care Programs with 1915(b) Waivers

Project No.:	500-92-0033DO02
Period:	September 1993–September 1995
Funding:	$ 752,256
Award:	Delivery Order in Master Contract
Principal Investigator:	James Lubalin, Ph.D.
Awardee:	Research Triangle Institute
	(See page 205)
HCFA Project Officer:	James P. Hadley Division of Health Systems and Special Studies

Description: The purpose of this contract is to design and conduct an evaluation of the Medicaid-managed care initiatives implemented through 1915(b) waivers. The evaluation will provide information to the Health Care Financing Administration and the States on the extent to which various features of the managed care projects

contribute to the ability of the Medicaid program to deliver cost-effective care to Medicaid-eligible populations. The evaluation will use interview data, studies submitted by the States as part of their waiver applications, and individual level use and cost data to examine the cost effectiveness of the projects, as well as the quality of care and satisfaction experienced by enrollees in the managed care programs relative to a fee-for-service alternative.

Status: The evaluation has begun with 1915(b) programs in California, Florida, New Mexico, Ohio, Washington, New York, and Wisconsin. Secondary data and use in cost-of-service as well as analysis of care-and-satisfaction studies will be obtained from California, Florida, New Mexico, and Ohio for analysis during fiscal year 1995.

93-056 Evaluation of the Medicare Case Management Demonstrations

Project No.:	500-92-0011DO02
Period:	July 1993–July 1996
Funding:	$ 700,846
Award:	Delivery Order in Master Contract
Principal Investigator:	Jennifer Shore
Awardee:	Mathematica Policy Research, Inc. (See page 208)
HCFA Project Officer:	David W. Walsh Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this contract is to evaluate the three Medicare Case Management Demonstrations. These demonstrations are designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. Specifically, this evaluation will test the operational feasibility and cost effectiveness of case management as a way of controlling Medicare beneficiaries' catastrophic health care costs in the Medicare fee-for-service sector.

Status: The evaluation contract was awarded on August 1, 1993. Mathematica Policy Research, Inc., is in the second year of the evaluation.

93-031 Evaluation of Medicare Select

Project No.:	500-93-0001
Period:	February 1993–February 1996
Funding:	$ 1,083,215
Award:	Contract
Principal Investigator:	Steven Garfinkel, Ph.D.
Awardee:	Research Triangle Institute P.O. Box 12194 Research Triangle Park, NC 27709-2194
HCFA Project Officer:	Rose M. Hatten Division of Health Systems and Special Studies
Mandate:	Section 4358(d) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Medicare Select is a pilot Medicare supplemental insurance product under which full Medigap benefits are paid only when services are provided by the plan's managed care network. The evaluation will consist of two components. First, case studies of each of the 15 States with operating Medicare Select plans will describe all aspects of the development and operational processes used by the State Insurance Commissioners, the National Association of Insurance Commissioners, and insurers to implement the Medicare Select provisions. Second, an analytical component will compare various measures associated with Medicare Select to other Medigap options. Measures will include cost and use of Medicare and supplemental services, selection effects, beneficiary satisfaction, and physician practice patterns.

Status: The contract was awarded in February 1993. Work on the case study component has been completed. The analytic component is proceeding.

90-058 Evaluation of the Municipal Health Services Program

Project No.:	500-87-0028TO15
Period:	September 1990–August 1993
Funding:	$ 735,869
Award:	Technical Support: Evaluation of Demonstrations (See page 216)
Principal Investigator:	Lyle Nelson, Ph.D.
Awardee:	Mathematica Policy Research, Inc.
HCFA Project Officer:	Ronald W. Deacon, Ph.D. Division of Health Systems and Special Studies

Mandate: Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: This project will evaluate the four Municipal Health Services Program (MHSP) demonstrations to determine cost effectiveness, beneficiary costs, and the quality of health services delivered in MHSP clinics. It will be undertaken in two phases. In Phase I, an intensive case study will be completed that will describe the organization and delivery of MHSP services and assess program operations to determine if the original goals and objectives of the demonstration continue to be met. The results of this phase will primarily describe the current process used by MHSP sites to serve the medical needs of its users. In Phase II, Medicare costs, quality of care, and the cost effectiveness of the demonstration will be determined. The cost and utilization experience for MHSP users will be compared with those of a control group for the years 1987, 1988, and 1989. The results of the evaluation will be presented in a Report to Congress.

Status: A final evaluation report was received in August 1993. The report concluded that the demonstration resulted in additional cost to the Medicare program because savings from reduced hospitalizations and emergency room use were not sufficient to cover the additional costs incurred by providing additional Medicare benefits. The report also concluded that the focus of the demonstration has shifted from provision of primary care to provision of ancillary services, such as pharmacy, podiatry, and dentistry. These evaluation results were reported in a February 1994 Report to Congress.

91-014 Evaluation of United Mine Workers of America Demonstration

Project No.:	500-87-0030TO11
Period:	June 1991–October 1994
Funding:	$ 457,040
Award:	Technical Support: Evaluation of Demonstrations (See page 216)
Principal Investigator:	William D. Marder, Ph.D.
Awardee:	Abt Associates Inc.
HCFA Project Officer:	Ronald W. Lambert Division of Health Systems and Special Studies

Description: The awardee will evaluate the United Mine Workers of America (UMWA) Health and Retirement Funds (the Funds) Medicare Part B capitation demonstration. This demonstration replaces the Funds' Health Care Prepayment Plan arrangement with the Health Care Financing Administration (HCFA), in which it is reimbursed for Medicare Part B services on a cost basis. In its place, the Funds will assume risk for Medicare Part B services under a capitated payment mechanism. The issues to be addressed are:

- An assessment of the cost effectiveness of capitation based on an analysis of changes in utilization and cost resulting from the demonstration.
- A detailed case study describing the cost management programs and changes occurring in the organization as a result of the demonstration.

Status: Abt Associates Inc. (Abt) has completed the first year report. Abt concluded that the demonstration had no measurable operational effect on the Funds beyond the obvious effect of ending the reimbursement dispute between HCFA and the Funds. Abt also examined the estimated Medicare Part B payments for which HCFA was responsible during the 3 years prior to the demonstration. The estimated capitated amount paid to the Funds for the first year of the demonstration was 22 percent higher than the average monthly payment amount during the year prior to the demonstration. The proportion of the Funds' beneficiaries is changing over time so that there are relatively fewer high-cost black lung beneficiaries. The final report will address the overall cost effectiveness of the demonstration.

92-037 Evaluation of the Utah Prepaid Mental Health Plan: Coordinated Care Systems as Alternatives to Traditional Fee for Service

Project No.:	18-C-90035/5
Period:	May 1992–April 1995
Funding:	$ 412,154
Award:	Cooperative Agreement
Principal Investigator:	Jon Christianson, Ph.D.
Awardee:	University of Minnesota 1100 Washington Avenue South Minneapolis, MN 55415-1226
HCFA Project Officer:	Paul J. Boben, Ph.D. Division of Health Systems and Special Studies

Description: The awardee will evaluate Utah's implementation of a "mental health maintenance organization" for its Medicaid beneficiaries. Under a section 1915 waiver from the Health Care Financing Administration, the State has signed contracts with three community mental health centers (CMHC) to provide mental health services to all Medicaid beneficiaries in

their catchment areas, which include 52 percent of all Medicaid beneficiaries in Utah, in return for capitated payments. The State hopes that this prepaid program will control the rapidly inflating costs of inpatient mental health care in its Medicaid program, while improving patient outcomes. The evaluation will examine how capitated rates are determined, beneficiaries are enrolled, and contracts are enforced. The evaluation also will examine the impact of the demonstration on the use and cost of mental health care received by Medicaid beneficiaries. The evaluation will use a mix of qualitative and quantitative research methodologies. Qualitative research methods will be used to assess the impact of Medicaid operations and the payment structure. The use and cost analysis will use quantitative research methodologies based on Medicaid claims and payment data. The National Institute of Mental Health is funding a companion study of the Utah program to examine the impact of the demonstration on a subgroup of high-risk beneficiaries—those individuals diagnosed as suffering from schizophrenia.

Status: The Health Care Financing Administration has received the report, "Expenditures and Utilization of Mental Health Service in the First Year of the Utah Prepaid Mental Health Plan," dated October 1993. Work continues on analysis of Medicaid record abstracts, paid claims data, and beneficiary surveys. A report on the second year of the demonstration is expected shortly.

91-001 Health First Demonstration

Project No.:	95-C-99631/3
Period:	December 1990–July 1994
Funding:	$ 102,256
Award:	Cooperative Agreement
Principal Investigator:	Robert Gibson
Awardee:	The Medical Center of Beaver, PA, Inc. 1000 Dutch Ridge Road Beaver, PA 15009
HCFA Project Officer:	Ronald W. Deacon, Ph.D. Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: For this project, the Medical Center will pool a group of employers and offer their retirees cost-effective health benefits. This will give small- to medium-sized employers the opportunity to participate in a Medicare insured group that would normally be available to only the very largest employers.

Status: During the feasibility phase, the Medical Center decided to terminate its cooperative agreement because of a change in management and a decision to not further pursue the Medicare insured group concept.

93-018 Integrated Information System for the Electronic Transfer and Validation of Provider Credentials for Coordinated Care Plans

Project Nos.:	97-P-08080/3-01 (Phase I) 97-P-08080/3-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 35,000 (Phase I) $ 150,000 (Phase II)
Award:	Grant
Principal Investigator:	Edward T. Porcaro
Awardee:	Credential Assurance Group of America 2650 Woodley Place, NW. Washington, DC 20008
HCFA Project Officer:	Michael J. Baier Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project will study the need for and feasibility of establishing an automated information system to electronically transfer and validate provider credentials for coordinated care plans. It also will evaluate the current technological capabilities of coordinated care plans to collect and transmit information.

Status: This project is in Phase II (testing and data gathering phase). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-061 Iowa Foundation for Medical Care Case Management Demonstration

Project No.:	95-C-90164/7
Period:	September 1992–September 1995
Funding:	$ 132,282
Award:	Cooperative Agreement
Principal Investigator:	Karen Coburn

Awardee:	Iowa Foundation for Medical Care 6000 Westown Parkway, Suite 350E West Des Moines, IA 50265-7771
HCFA Project Officer:	Rose M. Hatten Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The demonstration is designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. The Iowa Foundation for Medical Care will provide case management services to patients with one of two chronic conditions, chronic obstructive pulmonary disease and congestive heart failure. These conditions are diseases with known treatment variability and frequent rehospitalizations.

Status: Delivery of case management services began in October 1993. The operational phase is proceeding smoothly.

90-042 John Deere and Company Medicare Insured Group Research and Demonstration Project

Project No.:	95-C-99624/5
Period:	August 1990–August 1995
Funding:	$ 395,959
Award:	Cooperative Agreement
Principal Investigator:	Mel Scott
Awardee:	John Deere and Company John Deere Road Moline, IL 61265
HCFA Project Officer:	Ronald W. Deacon, Ph.D. Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: John Deere and Company (Deere) will conduct an initial feasibility study that includes collecting and analyzing historical trends of the cost and use of Medicare and Deere supplemental retiree benefits. If Deere determines that the Medicare insured group (MIG) concept is a financially feasible venture, it will design the specifics of the MIG demonstration, including the eligible retiree population, benefit package, ratesetting methodology, and approval of the health care delivery system.

Status: Deere completed the feasibility study in August 1991. Managed care initiatives would reduce Deere's costs for retirees by 7.3 percent, or 2.3 percent more than the amount retained by Medicare. Deere is proceeding to develop the specific operational tasks of the MIG demonstration and anticipates enrollment of retirees by January 1995.

92-009 Medicaid-Capitated Managed Care Program for Supplemental Security Income Disabled

Project No.:	18-C-90096/1
Period:	February 1992–October 1993
Funding:	$ 295,677
Award:	Cooperative Agreement
Principal Investigator:	Helen Batten, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Rose M. Hatten Division of Health Systems and Special Studies

Description: The objective of the project is to compare four types of health plans in terms of services provided to Supplemental Security Income (SSI) disabled participants in Medicaid. The project examines mandatory managed care capitated plans, mandatory fee-for-service, managed care plans, and voluntary managed care plans. A mail/telephone survey of administrators at an anticipated 100 plans currently offering services to SSI disabled consumers was conducted, followed by case studies of two examples of each of the four types of plans.

Status: A draft report was received in September 1994. The case study results indicate that the types of managed care plans available vary considerably.

92-023 Medicaid Capitation Rate Development

Project No.:	18-C-90135/3
Period:	February 1992–February 1995
Funding:	$ 473,326
Award:	Cooperative Agreement
Principal Investigator:	Gordon Trapnell
Awardee:	Actuarial Research Corporation 6928 Little River Turnpike, Suite E Annandale, VA 22003

HCFA Project Officer:	Ronald W. Lambert Division of Health Systems and Special Studies

Description: This project will develop a methodology that can be replicated by States to set capitation rates for Medicaid coordinated care plans. The project will be conducted in two phases. In the first phase, the quality of data from the Health Care Financing Administration's (HCFA) Medicaid Statistical Information System (MSIS) will be examined for three States to determine if these data are appropriate for capitation rate development. If MSIS data quality is not suitable, recommendations will be made regarding how the problems might be dealt with. HCFA will then decide whether to proceed to the methodology development phase. The second phase will involve the development of actuarial methods needed to set the rates. Separate rate cells will be developed for categories of enrollees that can have a large impact on overall payment to a plan. The methods for data base creation and ratesetting will be published in a manual that the States can use.

Status: The project is in the second phase. The awardee has submitted its report on capitation rate development, which describes methods of setting capitation rates based on upper payment limits, negotiation or competitive bidding. The Actuarial Research Corporation will prepare a manual for State use that describes the steps for calculating upper payment limits and capitation rates.

82-002 Minnesota Prepaid Medicaid Demonstration

Project No.:	11-C-98223/5
Period:	June 1982–June 1996
Funding:	$ 349,421
Award:	Cooperative Agreement
Principal Investigator:	Helen M. Yates
Awardee:	Minnesota Department of Public Welfare 2nd Floor–Space Center 444 Lafayette Road St. Paul, MN 55101
HCFA Project Officer:	Ronald W. Deacon, Ph.D. Division of Health Systems and Special Studies

Description: The Minnesota Department of Public Welfare was awarded a cooperative agreement to develop a prepaid capitation demonstration project for the eligible Medicaid population in three counties: one urban, Hennepin; one suburban, Dakota; and one rural, Itasca. For all counties, the per capita payment is based on the average fee-for-service cost per eligible person in the program in each county. This rate will be paid to competing health plans that organize to provide services to Medicaid recipients within the urban and suburban counties. A rate-cell approach is being used to pay capitation rates. The cells incorporate adjustments for age, sex, category of eligibility, county of residence, and institutional and Medicare status. The capitation rate for recipients under Aid to Families with Dependent Children will be 90 percent of the fee-for-service costs. For Supplemental Security Income recipients, the rate will be 95 percent of the fee-for-service costs.

Status: The State submitted an operational protocol that was approved by the Health Care Financing Administration in September 1985. The implementation phase began in Itasca County in September 1985, and in Hennepin and Dakota Counties in December 1985. There are presently at least three participating competing plans in each county. Initial enrollment was slower than anticipated because recipients failed to make choices (30-percent assignment rate); however, enrollment is now at 113,000. During 1992, enrollment was extended to the eligible population of Ramsay County. In 1995, the State plans to extend enrollment under the demonstration to several additional counties. This project was included in an earlier evaluation conducted by Research Triangle Institute. The demonstration was scheduled to end in December 1988, but Congress has extended it until June 1996.

79-001 Municipal Health Services Program: Baltimore, Maryland (Formerly, Municipal Health Services Program)

Project No.:	95-P-51000
Period:	August 1979–December 1997
Funding:	Waiver only
Award:	Service Agreement
Principal Investigator:	Bernadette G. Greene
Awardee:	City of Baltimore 111 North Calvert Street Baltimore, MD 21202
HCFA Project Officer:	Rosana Hernandez-Albertini Division of Health Systems and Special Studies

Description: Development of the Municipal Health Services Program (MHSP) was a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978, to

each of these cities: Baltimore, Cincinnati, Milwaukee, and San Jose. HCFA joined the project by providing Medicare and Medicaid waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities, the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

Status: MHSP waivers were scheduled to terminate on December 31, 1984; however, HCFA agreed to extend the Medicare waivers through December 1985. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1989, the demonstrations were extended to December 31, 1993. In addition, OBRA 1989 mandated that an independent evaluation regarding program cost effectiveness, beneficiary costs, quality of care, and other relevant factors be undertaken and that the findings of the evaluation be submitted in a Report to Congress. HCFA contracted with Mathematica Policy Research, Inc. (MPR), to perform the independent evaluation. MPR reported that the MHSP program has grown since 1985 in terms of cost and utilization. The total of gross Medicare waiver services costs for the MHSP program from fiscal year (FY) 1985 to FY 1992 was $225 million. A review of the MHSP cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, such as prescription drugs, dental care, and vision care. OBRA 1993 again extended the demonstration through December 31, 1997.

79-003 **Municipal Health Services Program: Cincinnati, Ohio** (Formerly, Municipal Health Services Program)

Project No.:	95-P-51000
Period:	August 1979–December 1997
Funding:	Waiver only
Award:	Service Agreement
Principal Investigator:	Malcolm P. Adcock, Ph.D.
Awardee:	City of Cincinnati 3101 Burnet Avenue Cincinnati, OH 45229
HCFA Project Officer:	Rosana Hernandez-Albertini Division of Health Systems and Special Studies

Description: Development of the Municipal Health Services Program (MHSP) was a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978, to each of these cities: Baltimore, Cincinnati, Milwaukee, and San Jose. HCFA joined the project by providing Medicare and Medicaid waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities, the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

Status: MHSP waivers were scheduled to terminate on December 31, 1984; however, HCFA agreed to extend the Medicare waivers, through December 1985. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1989, the demonstrations were extended to December 31, 1993. In addition, OBRA 1989 mandated that an independent evaluation regarding program cost effectiveness, beneficiary costs, quality of care, and other relevant factors be undertaken and that the findings of the evaluation be submitted in a Report to Congress. HCFA contracted with Mathematica Policy Research, Inc. (MPR), to perform the independent evaluation. MPR reported that the MHSP program has grown since 1985 in terms of cost and utilization. The total gross of Medicare waiver services costs for the MHSP program from fiscal year (FY) 1985 to FY 1992 was $225 million. A review of the MHSP cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, such as prescription drugs, dental care, and vision care. OBRA 1993 again extended the demonstration through December 31, 1997.

79-004 **Municipal Health Services Program: Milwaukee, Wisconsin** (Formerly, Municipal Health Services Program)

Project No.:	95-P-51000
Period:	August 1979–December 1997
Funding:	Waiver only
Award:	Service Agreement
Principal Investigator:	Samuel Akpan, Ph.D.

Awardee:	City of Milwaukee 841 North Broadway Milwaukee, WI 53202
HCFA Project Officer:	Rosana Hernandez-Albertini Division of Health Systems and Special Studies

Description: Development of the Municipal Health Services Program (MHSP) was a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978, to each of these cities: Baltimore, Cincinnati, Milwaukee, and San Jose. HCFA joined the project by providing Medicare and Medicaid waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities, the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

Status: MHSP waivers were scheduled to terminate on December 31, 1984; however, HCFA agreed to extend the Medicare waivers through December 1985. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1989, the demonstrations were extended to December 31, 1993. In addition, OBRA 1989 mandated that an independent evaluation regarding program cost effectiveness, beneficiary costs, quality of care, and other relevant factors be undertaken and that the findings of the evaluation be submitted in a Report to Congress. HCFA contracted with Mathematica Policy Research, Inc. (MPR), to perform the independent evaluation. MPR reported that the MHSP program has grown since 1985 in terms of cost and utilization. The total gross of Medicare waiver services costs for the MHSP program from fiscal year (FY) 1985 to FY 1992 was $225 million. A review of the MHSP cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, such as prescription drugs, dental care, and vision care. OBRA 1993 again extended the demonstration through December 31, 1997.

79-002 Municipal Health Services Program: San Jose, California (Formerly, Municipal Health Services Program)

Project No.:	95-P-51000
Period:	August 1979–December 1997
Funding:	Waiver only
Award:	Service Agreement
Principal Investigator:	JoAnn Foreman
Awardee:	City of San Jose 151 West Mission Street San Jose, CA 95110
HCFA Project Officer:	Rosana Hernandez-Albertini Division of Health Systems and Special Studies

Description: Development of the Municipal Health Services Program (MHSP) was a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978, to each of these cities: Baltimore, Cincinnati, Milwaukee, and San Jose. HCFA joined the project by providing Medicare and Medicaid waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities, the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

Status: MHSP waivers were scheduled to terminate on December 31, 1984; however, HCFA agreed to extend the Medicare waivers through December 1985. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1989, the demonstrations were extended to December 31, 1993. In addition, OBRA 1989 mandated that an independent evaluation regarding program cost effectiveness, beneficiary costs, quality of care, and other relevant factors be undertaken and that the findings of the evaluation be submitted in a Report to Congress. HCFA contracted with Mathematica Policy Research, Inc. (MPR), to perform the independent evaluation. MPR reported that the MHSP program has grown since 1985 in terms of cost and utilization. The total gross of Medicare waiver services costs for the MHSP program from fiscal year (FY) 1985 to FY 1992 was $225 million. A review of the MHSP cost reports

indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, such as prescription drugs, dental care, and vision care. OBRA 1993 again extended the demonstration through December 31, 1997.

87-003 Selectivity Bias Correction for the Medicare Adjusted Average Per Capita Cost

Project No.:	17-C-99040/5
Period:	June 1987–October 1990
Funding:	$ 499,601
Award:	Cooperative Agreement
Principal Investigator:	Bryan Dowd
Awardee:	University of Minnesota Institute for Health Services Research School of Public Health, Box 729 420 Delaware Street, SE. Minneapolis, MN 55455-0392
HCFA Project Officer:	Gerald F. Riley Division of Beneficiary Studies

Description: The primary objective of the project was to develop a methodology for producing unbiased estimates of the degree of biased selection present among health maintenance organization (HMO) enrollees. The project went beyond previous studies of biased selection by correcting for unobserved as well as observed characteristics of beneficiaries that influence both the beneficiaries' choices of health plan (i.e., HMO or fee-for-service) and the subsequent amount of resources consumed. The model produced an unbiased estimate of what a group of HMO enrollees would have cost if they had remained in fee-for-service; this is how the adjusted average per capita cost (AAPCC) is defined.

Status: The final report, "An Analysis of Selectivity Bias in the AAPCC," accession number PB94-187580, has been received and is available from the National Technical Information Service.

IM-018 Trends in Medicare Health Maintenance Organization Enrollment: 1986–93 (Formerly, Trends in Medicare Enrollment in Health Maintenance Organizations: 1986 to 1993)

Funding:	Intramural
HCFA Project Director:	Alma B. McMillan Division of Beneficiary Studies

Description: Using data from the monthly reports produced by the Office of Prepaid Health Care Operations and Oversight, Health Care Financing Administration, and published data from *InterStudy*, this study examined trends in national health maintenance organization (HMO) enrollment and Medicare HMO enrollment from 1986 to 1993. The analysis examined enrollment by State and by several characteristics of the HMO, such as type of HMO (independent practice association, group, staff, or network), profit status, and whether or not the HMO is part of a chain organization. It also examined benefits in addition to Medicare offered by HMOs and premiums for the extra benefits.

Status: This project has been completed. The report, "Trends in Medicare Health Maintenance Organization Enrollment: 1986–93," was published in the *Health Care Financing Review*, 15(1):135–146, Fall 1993. Study findings show that:

- Nationally HMO enrollment increased from about 10 percent of the U.S. population to 15 percent over the 7-year period of 1986–93; Medicare HMO enrollees increased from about 2 percent to 5 percent over the same period.
- Enrollment in Medicare HMOs continues to be heavily concentrated in a few large plans in California, Florida, and Arizona.
- Under Medicare plans, there was a shifting in the types of extra benefits offered in 1993 compared with those offered in 1986, e.g., a much smaller proportion of plans offered outpatient drugs in 1993 than those in 1986 (32 percent versus 70 percent).

90-023 United Mine Workers of America Demonstration

Project No.:	95-C-99643/3
Period:	July 1990–June 1995
Funding:	Waiver only
Award:	Cooperative Agreement
Principal Investigator:	Donald E. Pierce
Awardee:	UMWA Health and Retirement Funds 2021 K Street, NW. Washington, DC 20006
HCFA Project Officer:	Ronald W. Lambert Division of Health Systems and Special Studies

Description: The United Mine Workers of America (UMWA) Health and Retirement Funds (the Funds) is a waiver-only demonstration that provides a risk-based capitated payment for the Funds' Medicare-eligible retirees and dependents. The capitated payment replaces the Funds' cost-based health care prepayment plan arrangement. Approximately 88,000 Medicare eligibles are currently covered by the demonstration. This

demonstration affords the Health Care Financing Administration the opportunity to test the ability of a large multi-employer trust to administer and contain costs under a risk-based Medicare Part B capitation arrangement.

Status: The UMWA demonstration began on July 1, 1990, and is in its fifth year of operation. Capitated payments have been updated annually. For the first year of the demonstration, the audited cost report shows UMWA savings of over $3 million (1.9 percent of capitated payments). The unaudited cost report for the second year of the demonstration shows savings of over $8 million (4.8 percent of capitated payments). The unaudited cost report for the third year showed savings of $64 million (32 percent of capitated payments). For the fifth year of the demonstration this capitation rate was adjusted downward to more accurately reflect the actual costs experienced by the UMWA.

94-020 Use of Health Status Measures from the Medicare Current Beneficiary Survey to Improve the Adjusted Average Per Capita Cost

Project No.:	HCFA-94-0808
Period:	July 1994–October 1994
Funding:	$ 25,000
Award:	Contract
Principal Investigator:	Leonard Gruenberg, Ph.D.
Awardee:	DataChron Health Systems 763 Massachusetts Avenue, Suite 7 Boston, MA 02139
HCFA Project Officer:	Renee Mentnech Division of Beneficiary Studies

Description: The purpose of this project is to use the health status measures from the Medicare Current Beneficiary Survey to improve the adjusted average per capita cost (AAPCC) method of paying health maintenance organizations. Various health status adjusters will be compared. Both the combined and independent effects on future use and expenditures of self-reported health status, disability status, diagnostic cost group category, and the AAPCC factors will be examined.

Status: The detailed analysis plan has been completed, and the analytic file is being constructed

Provider Payment

92-047 Assessment of Policies for Transfer Cases and Outlier Cases

Project No.:	500-92-0023DO02
Period:	September 1992–September 1993
Funding:	$ 203,878
Award:	Delivery Order in Master Contract
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The RAND Corporation (See page 214)
HCFA Project Officer:	Sheila M. O'Dougherty Division of Payment and Economic Studies
Mandate:	Social Security Amendments of 1983 (Public Law 98-21)

Description: This project assessed current payment policies for hospital transfer and outlier cases under the Medicare prospective payment system (PPS) and made recommendations for potential policy changes. The project modeled the resources used by hospitals for transfer cases. Alternate transfer payment options were formulated and examined in simulations. The project also examined the effect of current hospital outlier policy on hospital charging behavior and on patterns of length of stay (LOS). Potential changes in outlier policies also were simulated.

Status: This project produced four separate reports. Two reports examine transfers, one on transferring hospitals and the other on receiving hospitals. The other two reports consider outlier cases—one evaluates the ratio of costs to charges and resulting cost estimates and the other examines low-cost outliers. The first report on transferring hospitals, "An Evaluation of Medicare Payments for Transfer Cases" (MR-304-HCFA), found that transfer cases are reimbursed for only two-thirds of their costs whereas nontransfer cases are reimbursed for 97 percent of costs. The average daily cost of transfer cases declines with LOS at a decreasing rate. A weighted regression model showed that the costs for the first day of a medical transfer case were approximately twice the current per diem rate; however, by the third day costs had declined almost to the current per diem rate. Using the cost model to pay for transfer cases results in a 30-percent improvement in the match of payment amounts to transfer case costs. The second transfer report, "Transfers of Medicare Hospital Patients under the Prospective Payment System" (PM-191-HCFA), found that the increase in transfer cases between fiscal year (FY) 1987 and FY 1991 can be explained

almost entirely by the increase in frequency of cardiac surgery and cardiac catheterization in the Medicare population. The study found that transfers appear to occur primarily for clinical reasons and that financial factors play at most a small role in the transfer decision. For these reasons, the report concluded that it is appropriate to align payments and costs for transfer cases as much as possible. In addition, the study found little evidence to support higher payments for hospitals receiving transfers. One of the outlier reports, "Cost Estimates for Cost Outlier Cases Under Medicare's Prospective Payment System" (MR-397-HCFA), describes the impact of the ratio of costs to charges (RCC) on cost outlier payments. Based on an analysis of the period PPS-3 through PPS-7, the report concludes that outlier payment policy could be improved by using separate RCCs for ancillary and accommodations charges and by deflating the ancillary RCCs to account for the temporal decline of ancillary RCCs. Although the improved cost measurement of outlier cases has only modest effects on payments and on the correlation between costs and payments, the cost of the improvement is very small. With the elimination of day outliers, the accuracy of cost outlier payments will become more important. The other outlier report, "Low Cost Outliers Under Prospective Payment" (PM-192-HCFA), analyzed a range of policies in which payment for profitable low-cost cases would be reduced. The amount of payment reductions was redistributed across all cases in a budget-neutral manner. The report concludes that low-cost outlier policies are feasible and appear to have certain desirable properties. However, a definitive judgment about the policy's value requires more clinical information about low-cost cases than was available for this study. The final policy judgment requires a decision about whether low-cost cases are low cost because the patients have low-resource needs or because the hospital is extremely efficient. The authors of all four reports are Grace M. Carter and J. David Rumpel. Copies can be obtained from RAND, 1700 Main Street, Post Office Box 2138, Santa Monica, California 90407-2138.

94-002 Assessment and Redesign of Medicare Fee Schedule Areas (Localities)

Project No.:	500-92-0020DO09
Period:	July 1994–April 1995
Funding:	$ 125,882
Award:	Delivery Order in Master Contract
Principal Investigator:	Gregory C. Pope, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Division of Payment and Economic Studies

Description: The purpose of this delivery order is to reassess the current 216 Medicare Part B pricing locality areas to determine the feasibility of using some other geographic configuration such as States, metropolitan statistical areas, or county groupings as Medicare fee schedule areas (MFSA). Currently, there is no standard geographic definition of a Medicare payment locality. In 21 States, the entire State is a single payment locality. In the remaining 29 States, there are multiple localities, ranging from 32 in Texas to 2 localities in Idaho, Massachusetts, Michigan, and Mississippi. Localities were established by Medicare fiscal agents, known as carriers, to reflect local differences in medical practice and economic conditions. Once established, localities could not be changed without reason. Consequently, except for several consolidations, usually to a State locality, Medicare physician payment boundaries have remained relatively stable since the inception of the program in 1966. Over time some of the distinctions that dictated the original locality definitions may no longer be meaningful, and thus, the Health Care Financing Administration intends to reassess the current multistate MFSAs.

Status: This project is in the early developmental stage.

89-025 Billing Patterns for Critical-Care Physician Services

Project No.:	99-C-99168/3
Period:	August 1989–July 1993
Funding:	$ 99,559
Award:	Cooperative Agreement
Principal Investigator:	Louis Garrison, Ph.D.
Awardee:	The People-to-People Health Foundation, Inc. (See page 210)
HCFA Project Officer:	William Buczko, Ph.D. Division of Payment and Economic Studies

Description: This project evaluated the potential for bundling payments for critical-care physician services under Medicare into more inclusive payment packages. Critical-care physician services are provided in coronary care, intensive care, or other emergency care units of hospitals. Current Procedural Terminology (CPT) critical-care coding and its relationship to Intensive Care Unit/Coronary Care Unit (ICU/CCU) utilization based on

data from a merged 1987 Part A and Part B file for a 5-percent sample of Medicare beneficiaries was examined, and an assessment of the feasibility of using CPT critical care codes for bundling services into critical-care episodes for reimbursement was presented.

Status: The final report, "A Descriptive Analysis of Medicare Hospital Episodes with Critical Care Billings: Implications for Bundling Services for Pricing," has been received in the Office of Research and Demonstrations. It found that substantial inconsistency and variations existed in both critical-care coding practices and billing patterns for critical care. Billings for critical care represented only a small portion of charges for the total hospital episode, especially when compared to billing for physician services. Many hospital stays involving ICU/CCU use did not have any associated billings for critical care. The findings presented suggest that coding of critical-care services needs clarification and improvement, and there may be limited utility in the bundling-based provision of critical-care services. This report is available from the National Technical Information Service, accession number PB94-104429.

92-030 **Bundling Physician Services**

Project No.:	500-89-0050
Period:	March 1992–March 1995
Funding:	$ 354,418
Award:	Contract
Principal Investigator:	A. James Lee, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Teresa L. DeCaro Division of Payment and Economic Studies

Description: The purpose of this project is to develop and evaluate innovative alternatives to packaging ancillary services with physician office-based visits. It involves five discreet tasks including assessing the reliability of diagnostic coding and Unique Physician Identification Numbers (UPIN) in the 1992 Part B National Claims History data; developing a criteria paper to guide the development and evaluation of alternative bundling strategies; conducting descriptive analyses of various ancillary bundles; exploring the application of ambulatory patient group (APG) assignment and weighing algorithms to physician services provided in an office setting; and simulating redistributive impacts of various bundling strategies.

Status: Three reports have been produced including "An Exploratory Investigation of UPIN and Diagnostic Reporting in the National Claims History;" "Descriptive Analysis of Ancillary Service Bundles;" and "Criteria Paper: Issues in Visit-Based Bundling." The criteria paper is available from the National Technical Information Service, accession number PB93-184158. It explores equity-efficiency tradeoffs using various examples of bundles that conceptually make up a packaging continuum. Design issues are discussed, and evaluation criteria are developed, including cost reduction potential, redistributive consequences, potential for inappropriate responses, and administrative feasibility. The study's two principal analytic tasks remain to be completed. The APG task will begin when the second generation grouper is completed. The simulation task has been redesigned to include two investigations. The first investigation will explore diagnosis-based bundling in which the relative value units associated with a selected number of high-volume, low-cost ancillaries (and their close substitutes) are loaded onto visits and consultations according to the diagnosis grouping assigned to the visit claim. Distributive impacts of ancillary bundling on various physician groupings will be modeled. The second investigation will examine the actual utilization of ancillaries during ambulatory care for a selected number of acute and chronic conditions and will compare this to practice guidelines for these conditions. Analytic files are being constructed from the 1992 5-percent physician/supplier Part B Claims data for these analyses.

93-085 **Canadian Physician Organizations' Response to Global Budgets**

Project No.:	500-93-0013
Period:	September 1993–September 1994
Funding:	$ 37,924
Award:	Contract
Principal Investigator:	Stephen J. Katz, M.D.
Awardee:	The University of Michigan Department of Internal Medicine Division of General Medicine 3116 Taubman Center Ann Arbor, MI 48109-0376
HCFA Project Officer:	Leslie M. Greenwald, Ph.D. Office of the Director Office of Research

Description: This project will examine the process and structure of the negotiations and conflict resolution between medical specialty organizations in Canada when faced with a global budget for physician services. The project also will examine the related issues of differences

in physician specialty mix between Canada and the United States and the structure and mission of medical organizations in the two countries.

Status: A final report is expected in late October 1994.

90-005 Changes in Hospital Wages since Implementation of the Prospective Payment System

Project No.:	17-C-99500/1
Period:	October 1989–October 1993
Funding:	$ 212,478
Award:	Cooperative Agreement
Principal Investigator:	Gregory C. Pope, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) Hillsite Office Building 75 Second Avenue, Suite 100 Needham, MA 02194
HCFA Project Officer:	Edgar A. Peden, Ph.D. Division of Payment and Economic Studies
Mandate:	Social Security Amendments of 1983 (Public Law 98-21)

Description: In this project Health Economics Research researchers examine the determinants of hospital wages using the Health Care Financing Administration's (HCFA) wage surveys from 1982, 1984, and 1988; the American Hospital Association's (AHA) annual surveys; and the Bureau of Labor Statistics' (BLS) industry wage surveys. Labor costs account for more than one-half of all hospital costs. For individual hospitals, these costs are affected by hospital occupation mix, wages earned in alternative employment (opportunity wages), labor productivity, inpatient volumes, and the cost of living. Using regression analysis, this project investigates empirically the linkages of these factors to labor costs.

Status: The awardee reviewed the literature on hospital and firm wage determination, constructed a model of wage determination, and made estimates of the model based on data received from HCFA, the BLS, and the AHA. This study finds that the major determinants of hospital average hourly compensation are area opportunity wages (i.e., the amount hospital workers could earn in alternative occupations in an area); area hospital-specific opportunity wages; hospital size; hospital case mix; hospital occupation mix; hospital unionization; and the competitiveness of the area labor market. Opportunity wages have by far the largest effect on hospital wages. Nevertheless, the other factors, especially taken as a group, have a significant impact on wages. Together, the above seven variables explain about 70 percent of the variation in hospital wages. Health Economics Research researchers suggest various policy changes that HCFA might make in paying the wage portion of costs under the prospective payment system. These include refining the wage survey instrument, using wage data from the decennial census, and statistically removing the effects of various factors on the wage index. The final report, "Hospital Wages and the Prospective Payment System," accession number PB94-207560, is available from the National Technical Information Service.

94-008 Collect Malpractice Insurance Premium Rate Information

Project No.:	500-94-0039
Period:	July 1994–June 1997
Funding:	$ 347,892
Award:	Contract
Principal Investigator:	Karen Reilly, Sc.D.
Awardee:	Allied Technology Group, Inc. 1803 Research Boulevard, Suite 601 Rockville, MD 20850
HCFA Project Officer:	Benson L. Dutton Division of Payment and Economic Studies

Description: The study will survey State insurance commissioners, physician-owned malpractice insurers, physician associations, cooperatives, and physician joint underwriting associations. Premium rate data will be obtained from State insurance departments. These data will be used by the Health Care Financing Administration (HCFA) staff and outside contractors to update the malpractice component of the Medicare Economic Index (MEI) and to refine the malpractice component of the geographic practice cost index (GPCI) for the Medicare fee schedule (MFS). By law, HCFA is required to compute the annual rate of increase in malpractice insurance costs for use in the MEI and to periodically review and update the GPCI. Section 1848(e) of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Public Law 101-239) and section 4118(c) of OBRA 1990 (Public Law 101-508) require the Secretary of Health and Human Services to develop and update geographic adjustment factors for existing payment localities used in calculating the MFS. The first task under this project will be the preparation of a research design and an analysis plan. Other tasks include developing methods for collecting representative premium data for the national MEI estimates and the GPCI market areas; interviewing State insurance commissioners' staff to identify physician medical liability insurance

companies in the State; collecting $1 million/$3 million malpractice premium rates for policies for 1993–95 from State insurance commissioners' office files, if available, and otherwise, through contacting key insurance company personnel named by the State insurance office; identifying any sub-State coverage and pricing areas; investigating possible expansion to the survey; determining the existence, composition, and authority of any State patient compensation funds and joint underwriting associations; and linking the 1993–95 premium data collected under this survey with the 1989–92 data collected previously.

Status: This project is in its early developmental stage. A draft research design describing the methods and the process used to conduct the survey and an analysis plan establishing the basis for initial insurance plan selection and alternative source selection have been prepared.

92-007 **Data for Hospital Cost Monitoring and Analysis of Hospital Costs**

Project No.:	500-92-0003
Period:	January 1992–December 1996
Funding:	$ 715,700
Award:	Contract
Awardee:	American Hospital Association 840 North Lake Shore Drive Chicago, IL 60611
HCFA Project Officer:	Alvin L. Freedman Division of Payment and Economic Studies
Mandate:	Social Security Amendments of 1983 (Public Law 98-21)

Description: The Health Care Financing Administration (HCFA) will receive from the American Hospital Association (AHA) the output from its National Hospital Panel Survey and Annual Survey of Hospitals for fiscal years (FY) 1992–96. These data will serve as a prime source of outside data on the performance of hospitals and will be used in HCFA analyses, research, and publications.

Status: HCFA has received monthly *National Hospital Panel Survey Reports* and monthly *Hospital Statistics* through March 1994. The Annual Survey of Hospitals for FY 1993 is expected in December 1994. These data and reports are available only from the AHA.

94-097 **Demonstration of Managed Care under Medicare Using Volume Performance Standards Organizations**

Project No.:	95-C-90388/1
Period:	September 1994–March 1998
Funding:	$ 350,000
Award:	Cooperative Agreement
Principal Investigator:	Christopher P. Tompkins, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Teresa L. DeCaro Division of Payment and Economic Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: The purpose of this project is to develop specifications for a physician group practice volume performance standard (GPVPS) model which can be demonstrated. The first and only funded phase of this project is a year of development work in which the specifications for the physician GPVPS models are being finalized. Analyses and review of the specifications by a technical advisory panel are intended to produce sufficient evidence to judge the feasibility and acceptability of these models for demonstration. Two prior studies (99-C-98526/1 and 17-C-90129/1) and this project respond to legislation enacted along with the implementation of the national Medicare volume performance standard (MVPS) in the Omnibus Budget Reconciliation Act of 1989 (Section 1848f.4). The legislation specifies that the Secretary shall implement a plan under which qualified physician groups can elect annually separate performance standard rates of increase other than the national standard established for the year. A GPVPS is one such alternative which would operate within the context of the existing national MVPS. Basically, the rate of increase in the volume and intensity of services to Medicare patients seen by each participating organization will be compared to a target rate of increase. The Health Care Financing Administration would maintain its influence over the national aggregate expenditures through the MVPS, but would give incentives and rewards to physician organizations for efficiency. The specified models may go beyond the category of physician services that are affected by the MVPS definition by providing qualified

service delivery organizations incentives to manage all Medicare-covered services. Following final development work, this project may be funded to demonstrate the following goals:

- Test whether selected physician organizations can improve the efficiency of service delivery for Medicare beneficiaries in the fee-for-service sector.
- Test and refine reimbursement and incentive systems that award providers for delivering care efficiently.
- Develop new techniques for using information for organizational and clinical decisionmaking (profiling) to facilitate controlling costs without sacrificing quality or access to care.
- Target GPVPS models at selected physician group practices that could represent "best practices" and provide clinical and managerial leadership toward the objective of improved efficiency in the fee-for-service market.

Status: This project is in the early developmental phase.

91-073 Design and Evaluation of a Prospective Payment System for Ambulatory Care

Project No.:	17-C-90057/5
Period:	September 1991–September 1994
Funding:	$ 950,849
Award:	Cooperative Agreement
Principal Investigator:	Richard Averill
Awardee:	3M-Health Information Systems 100 Barnes Road Wallingford, CT 06492
HCFA Project Officer:	Joseph M. Cramer Division of Hospital Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: In 1989, the Health Care Financing Administration (HCFA) awarded 3M-Health Information Systems (3M-HIS) a 2-year grant to develop a patient classification system that could be used as the basis of payment for an outpatient prospective payment system (PPS) for Medicare. 3M-HIS finished development of a complete set of ambulatory patient groups (APG) along with a set of payment weights and prepared a final report. The purpose of this project is to update the prior work done on APGs using a new data base. The project addresses a broad range of issues including care in the emergency room, determination of payment for outliers, and incorporation of a review of all the basic components on an APG-based PPS. The research consists of three phases:

- Phase I. Update the existing APG classification scheme.
- Phase II. Evaluate APGs using a new data base, make necessary modifications, compute APG payment weights, and simulate an APG-based payment system.
- Phase III. Propose and test a revision of parts of the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis codes.

Status: 3M-HIS updated the APG definitions based on recommendations from outside evaluators and a review of procedure APGs with additional data. The APGs also were updated for changes in the *Current Procedural Terminology, 4th Revision* procedure codes and ICD-9-CM diagnosis codes. 3M-HIS worked with HCFA on the creation of an analysis data base from the HCFA common working file (CWF). Using the CWF data base, each APG was reevaluated by 3M-HIS and HCFA staff; appropriate changes are being made to the groups. 3M-HIS also is addressing a series of policy issues prior to developing complete payment models. 3M-HIS proposed new ICD-9-CM diagnosis and functional status codes that affect the medical APGs. The codes were tested in New York State primarily for rehabilitation and mental health services, and 3M-HIS is analyzing the results.

90-068 Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement: Illinois (Formerly, Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement)

Project No.:	29-P-99397/5
Period:	October 1989–May 1995
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Cheryl Morris
Awardee:	RMS Health Providers Joint Venture of Suburban Hospital/Rush Presbyterian Hospital Hinsdale, IL 60521
HCFA Project Officer:	Michael Henesch Division of Hospital Experimentation
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Four sites have implemented the demonstration: Mayo Foundation in Rochester, Minnesota; RMS Health Providers in Chicago, Illinois; Sinai Hospital in Detroit, Michigan; and Temple University Hospital in Philadelphia, Pennsylvania. The demonstration will be used to determine the appropriateness of reclassifying ventilator-dependent hospital components as rehabilitation units for purposes of Medicare reimbursement. The demonstration is for a period of 3 years corresponding to each site's fiscal year. Start dates ranged from July 1, 1991, to July 1, 1992. Standard admission criteria for use across the sites were developed in cooperation with the demonstration sites and are used by the professional review organization to evaluate admissions and discharges. An empirical analysis will be conducted to compare the cost of the services, quality of care, and patient outcomes for demonstration patients to patients in a control group. The analysis also will examine the demonstration sites, as well as alternative care settings in the private sector, to evaluate the effect of modifications in reimbursement policy shifting from a prospective payment system for these units to the Tax Equity and Fiscal Responsibility Act method of reimbursement. Based on the results of the evaluation, the Health Care Financing Administration will be able to determine the appropriate policy for paying for the hospital care of chronic ventilator patients.

Status: The administrative processes instituted for the demonstration, such as the assignment of new provider numbers for the units, reporting requirements of the fiscal intermediaries, and the modification of peer review organization contracts to operate the demonstration, have been implemented. Data are being collected at each site. This site will operate under the demonstration waiver until May 31, 1995.

90-069 **Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement: Michigan** (Formerly, Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement)

Project No.:	29-P-99408/3
Period:	October 1989–June 1995
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Diane Czlonka
Awardee:	Sinai Hospital of Detroit Detroit, MI 48235
HCFA Project Officer:	Michael Henesch Division of Hospital Experimentation
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Four sites have implemented the demonstration: Mayo Foundation in Rochester, Minnesota; RMS Health Providers in Chicago, Illinois; Sinai Hospital in Detroit, Michigan; and Temple University Hospital in Philadelphia, Pennsylvania. The demonstration will be used to determine the appropriateness of reclassifying ventilator-dependent hospital components as rehabilitation units for purposes of Medicare reimbursement. The demonstration is for a period of 3 years corresponding to each site's fiscal year. Start dates ranged from July 1, 1991, to July 1, 1992. Standard admission criteria for use across the sites were developed in cooperation with the demonstration sites and are used by the professional review organization to evaluate admissions and discharges. An empirical analysis will be conducted to compare the cost of the services, quality of care, and patient outcomes for demonstration patients to patients in a control group. The analysis also will examine the demonstration sites, as well as alternative care settings in the private sector, to evaluate the effect of modifications in reimbursement policy shifting from a prospective payment system for these units to the Tax Equity and Fiscal Responsibility Act method of reimbursement. Based on the results of the evaluation, the Health Care Financing Administration will be able to determine the appropriate policy for paying for the hospital care of chronic ventilator patients.

Status: The administrative processes instituted for the demonstration, such as the assignment of new provider numbers for the units, reporting requirements of the fiscal intermediaries, and the modification of peer review organization contracts to operate the demonstration, have been implemented. Data are being collected at each site. This site will operate under the demonstration waiver until June 30, 1995.

90-067 **Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement: Minnesota** (Formerly, Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement)

Project No.:	29-P-99424/5
Period:	October 1989–December 1994
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Douglas R. Gracey, M.D.

Awardee:	Mayo Foundation St. Mary's Hospital Rochester, MN 55905
HCFA Project Officer:	Michael Henesch Division of Hospital Experimentation
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Four sites have implemented the demonstration: Mayo Foundation in Rochester, Minnesota; RMS Health Providers in Chicago, Illinois; Sinai Hospital in Detroit, Michigan; and Temple University Hospital in Philadelphia, Pennsylvania. The demonstration will be used to determine the appropriateness of reclassifying ventilator-dependent hospital components as rehabilitation units for purposes of Medicare reimbursement. The demonstration is for a period of 3 years corresponding to each site's fiscal year. Start dates ranged from July 1, 1991, to July 1, 1992. Standard admission criteria for use across the sites were developed in cooperation with the demonstration sites and are used by the professional review organization to evaluate admissions and discharges. An empirical analysis will be conducted to compare the cost of the services, quality of care, and patient outcomes for demonstration patients to patients in a control group. The analysis also will examine the demonstration sites, as well as alternative care settings in the private sector, to evaluate the effect of modifications in reimbursement policy shifting from a prospective payment system for these units to the Tax Equity and Fiscal Responsibility Act method of reimbursement. Based on the results of the evaluation, the Health Care Financing Administration will be able to determine the appropriate policy for paying for the hospital care of chronic ventilator patients.

Status: The administrative processes instituted for the demonstration, such as the assignment of new provider numbers for the units, reporting requirements of the fiscal intermediaries, and the modification of peer review organization contracts to operate the demonstration, have been implemented. Data are being collected at each site. This site will operate under the demonstration waiver until December 31, 1994.

90-070 **Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement: Pennsylvania** (Formerly, Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement)

Project No.:	29-P-99401/3
Period:	October 1989–June 1994
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Gerard J. Criner, M.D.
Awardee:	Temple University Hospital Philadelphia, PA 19140
HCFA Project Officer:	Michael Henesch Division of Hospital Experimentation
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Four sites have implemented the demonstration: Mayo Foundation in Rochester, Minnesota; RMS Health Providers in Chicago, Illinois; Sinai Hospital in Detroit, Michigan; and Temple University Hospital in Philadelphia, Pennsylvania. The demonstration will be used to determine the appropriateness of reclassifying ventilator-dependent hospital components as rehabilitation units for purposes of Medicare reimbursement. The demonstration is for a period of 3 years corresponding to each site's fiscal year. Start dates ranged from July 1, 1991, to July 1, 1992. Standard admission criteria for use across the sites were developed in cooperation with the demonstration sites and are used by the professional review organization to evaluate admissions and discharges. An empirical analysis will be conducted to compare the cost of the services, quality of care, and patient outcomes for demonstration patients to patients in a control group. The analysis also will examine the demonstration sites, as well as alternative care settings in the private sector, to evaluate the effect of modifications in reimbursement policy shifting from a prospective payment system for these units to the Tax Equity and Fiscal Responsibility Act method of reimbursement. Based on the results of the evaluation, the Health Care Financing Administration will be able to determine the appropriate policy for paying for the hospital care of chronic ventilator patients.

Status: The administrative processes instituted for the demonstration, such as the assignment of new provider numbers for the units, reporting requirements of the fiscal intermediaries, and the modification of peer review

organization contracts to operate the demonstration, have been implemented. Data are being collected at each site. This site stopped operating under the demonstration waiver on June 30, 1994. The site continues to extract and provide data under the evaluation.

91-075 Developing Cost Control Policies for Medicare Outpatient Services

Project No.:	17-C-90036/3
Period:	September 1991–September 1994
Funding:	$ 333,923
Award:	Cooperative Agreement
Principal Investigator:	Margaret Sulvetta, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Mark A. Krause, Ph.D. Division of Hospital Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The objective of this project is to provide the Health Care Financing Administration with information to design cost control policies for care delivered in hospital outpatient departments. In particular, the information will be useful in the development of a prospective payment system for such services. The study principally addresses these questions:

- What are the average costs and the group variation of costs defining the units of service to bundle different ranges of ancillary services?
- What are the technical implications of bundling payment for physicians' services with those of facility payment?
- What affiliation patterns do physicians have with hospitals and is physicians' work concentrated among very few facilities?
- What proportion of the growth in outpatient expenditures is attributable to general inflation, service-specific inflation, increases in visits, increases in services per visit, or to a shift in the types of services?
- How do charges, Medicare calculated costs, and resource costs (from the Center for Health Policy Studies' analysis) compare absolutely and relatively?

Status: This project's tasks are largely dependent on the completion of the ambulatory patient groups (APG) computer software grouper [Version 2] being developed by 3M-Health Information Systems. A separate task is dependent on the work related to resource costs being conducted by the Center for Health Policy Studies. Because of the interdependent nature of this research, this project has been granted no-cost extensions to complete the assigned tasks. Other components of the project required many different data bases. A file for outpatient bills for the first quarter of 1992 became available in late 1992. The work on physicians services requires claims with unique physician identifiers, which are comprehensively used in only certain States. Physician claims and facility bills were linked for each of the sampled States in late 1992. The remainder of the analytical work will be completed in 1994.

94-111 Development of a Physician Prospective Payment System for Ambulatory Care

Project No.:	17-C-90309/5
Period:	September 1994–March 1996
Funding:	$ 421,451
Award:	Cooperative Agreement
Principal Investigator:	Merritt R. Marquardt
Awardee:	Minnesota Mining and Manufacturing Company Health Information Systems St. Paul, MN 55144-1000
HCFA Project Officer:	Mark A. Krause, Ph.D. Division of Hospital Experimentation

Description: The objective of this project is to develop for the Health Care Financing Administration a new patient classification system that can be used as a basis for a prospective payment system (PPS) for physician services. This new patient classification system will be based on a previously developed patient classification system for the facility component of outpatient services constructed by 3M-Health Information Systems. This system called ambulatory patient groups (APG) has been in existence since 1990 and is being employed as a payment methodology by several payers. This physician PPS analysis will augment the APGs to encompass the professional as well as the facility component of ambulatory care. The classification methodology will be called physician care groups (PCG). The development of PCGs will be based on a comprehensive analysis of the Medicare physician payment data base as well as on other non-Medicare data bases. The completion of this research will provide an alternative classification system for the payment of physicians that, in combination with the APGs, may provide a coordinated basis for the

implementation of a PPS for both the professional and facility costs of ambulatory care.

Status: The project is in the early development stage.

90-036 Diagnostic Testing: Policy Analysis of Pricing Options

Project No.:	99-C-99169/5
Period:	August 1990–July 1993
Funding:	$ 99,979
Award:	Cooperative Agreement
Principal Investigator:	Mark V. Pauly, Ph.D.
Awardee:	The University of Minnesota (See page 217)
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies

Description: The objective of this project was to devise a pricing policy for the technical component of selected diagnostic tests performed by physicians that comes as close as possible to incentive neutrality and paying fair prices. The University of Minnesota, through a subcontract with the University of Pennsylvania, conducted the study. The project identified a few overpriced procedures and discussed the impact of physician reimbursement on physician behavior, specifically the incentives to make capital investments in diagnostic testing equipment. The report also identified a few diagnostic tests for which access to care considerations might require high-reimbursement levels adequate to ensure timely critical care.

Status: The final report, "Diagnostic Testing: Policy Options of Pricing Options," accession number PB94-154887, by Mark V. Pauly, Orit Even-Shoshan, and Marilyn Friedman is available from the National Technical Information Service.

91-060 Efficient Volume Pricing of the Technical Component for Diagnostic Procedures

Project No.:	99-C-99169/5
Period:	August 1991–July 1993
Funding:	$ 121,503
Award:	Cooperative Agreement
Principal Investigator:	Mark V. Pauly, Ph.D.
Awardee:	The University of Minnesota (See page 217)
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies

Description: This was an examination of the Medicare pricing policy for the technical component of specified diagnostic tests performed by physicians in their offices. The University of Minnesota, through a subcontract with the University of Pennsylvania, conducted the study. Previous work examined volume-dependent pricing options and indicated that Medicare payments for some diagnostic procedures were above estimated fair market prices. For this study, researchers are investigating a pricing policy for the technical component of diagnostic tests based on efficient prices—the price at which an efficient provider would make a modest profit.

Status: The final report, "Diagnostic Testing: Efficient Volume Pricing of the Technical Component for Diagnostic Procedures," by Mark V. Pauly, Orit Even-Shoshank, Steven Wall, *et al.* will be sent to the National Technical Information Service. Its main conclusions are:

- The fair-rate-of-return methodology provides a timely and reliable method of identifying improperly priced procedures and, if some uncertainty about experts' subjective judgment is tolerable, this methodology may be used for ratesetting purposes.
- The 1991 Medicare reimbursement for the technical component of some diagnostic tests is in excess of the "fair" or "competitive return" price. Of the procedures studied, 13 generally appeared to be overpriced procedures, 10 were properly priced; and most orthopedic and chest x rays for high-cost specialists were underpriced procedures.
- A few of the procedures studied appeared to be candidates for volume-based pricing (i.e., higher prices for low-volume providers), but the majority appropriately could be reimbursed by a "typical" single price.

94-017 Evaluating Methods of Estimating Hospital Efficiency

Project No.:	500-93-0029DO02
Period:	December 1993-April 1995
Funding:	$ 296,575
Award:	Delivery Order in Master Contract
Principal Investigator:	Robert J. Schmitz, Ph.D.
Awardee:	Abt Associates Inc. (See page 211)
HCFA Project Officer:	William L. England, Ph.D. Division of Payment and Economic Studies

Description: This project is performing data envelopment analysis (DEA) using IDEAS software, and stochastic

frontier analysis (SFA) using LIMDEP v6 software, to assess the process by which hospitals provide patient care "output" as a function of input prices, in an effort to measure the elusive concept of hospital efficiency and quality of care. These methods assume that "similar" hospitals should produce equivalent patient care at similar costs and the extent to which they differ is a measure of inefficiency. The definition of "similar" is critical to the analysis, and Phase I of this project is reviewing the literature on DEA and SFA to determine what variables (e.g., size, case-mix, teaching status, local wage level) should be used to adjust for differences among hospitals. In Phase II, a computer simulation model will be developed to generate data from a known model of hospital cost and efficiency. This model will be used to assess the ability of DEA and SFA to estimate the true efficient frontier, and to measure the cost of inefficiency, by "endowing" the model with given degrees of inefficiency. The model also will be used to assess the validity and robustness of DEA and SFA to random noise, measurement error, and missing data. Data for the model will include institution-specific employment data from the American Hospital Association; data from the Health Care Financing Administration's (HCFA) Hospital Cost Report Information System; Census data; State-specific files, including data from the California Office of Statewide Health Planning and Development and the Pennsylvania Mediqual data base; and data on individual stays for Medicare beneficiaries from HCFA's Medicare provider analysis and review data base.

Status: This project just completed acquisition of the data bases required to support the modeling effort, and no preliminary results are available.

89-004 Evaluation of the Physician Preferred Provider Organization Demonstration

Project No.:	500-87-0028TO13
Period:	June 1989–May 1994
Funding:	$ 1,185,697
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Harold S. Beebout, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 216)
HCFA Project Officer:	Victor G. McVicker Division of Hospital Experimentation

Description: In January 1989, five preferred provider organizations (PPO) were selected to participate in the Medicare physician PPO pilot demonstration. Selected sites included Blue Cross and Blue Shield of Phoenix, Arizona; HealthLink, Inc., St. Louis, Missouri; CareMark, Inc., Portland, Oregon; The Araz Group (formerly, Family Health Plan), Bloomington, Minnesota; and CAPP CARE, Inc., Newport Beach, California. The purpose of evaluating the pilot demonstration is to assess the operational feasibility of the Medicare physician PPO concept. To facilitate this assessment, the implementation and operational experience of the pilot PPOs will be evaluated comprehensively using case study methods. The assessment will include an analysis of biased selection, beneficiary choice, provider practice patterns, and the impact of the demonstration on Medicare costs and utilization of each site. Because each site is a unique model, the awardee, Mathematica Policy Research, Inc., will examine the unique features of each site and will look at how these features contribute to the success of the site.

Status: Blue Cross and Blue Shield of Arizona, CAPP CARE, and the Araz Group implemented the demonstration in January 1990, March 1990, and January 1992, respectively. CareMark and HealthLink withdrew from the demonstration prior to implementation. The following reports are available from the National Technical Information Service (NTIS):

- "Blue Cross and Blue Shield of Arizona Medicare Physician PPO Demonstration Status Report," accession number PB91-106906.
- "Status of the Medicare PPO Demonstration Early Implementation Experience of: CAPP CARE, Family Health Plan, HealthLink, CareMark," accession number PB93-l18057.
- "Beneficiary Attitudes Toward and Experiences with Medicare Demonstration PPOs Evidence from the Phoenix, Arizona and Orange County, California Structured Discussion Groups," accession number PB93-l16374.
- "Evaluation Design Report for the Medicare Physician Preferred Provider Organization Demonstration," accession number PB92-236025.
- "Implementation of the Medicare Physician Preferred Provider Organization (PPO) Demonstration," accession number PB94-208923.
- "Interim Report on Beneficiary Use and Cost of Services for the CAPP CARE Preferred Provider Organization Demonstration," accession number PB94-203064.

The final evaluation report on the demonstration has been received and accepted and is being sent to NTIS.

90-012 Evaluation of the Ventilator-Dependent Unit Demonstration

Project No.:	500-87-0029TO05
Period:	October 1989–September 1995
Funding:	$ 1,034,030
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Theresa Mullin, Ph.D.
Awardee:	Lewin/VHI, Inc. (See page 216)
HCFA Project Officer:	Michael Henesch Division of Hospital Experimentation
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Treating ventilator-dependent patients in hospitals is labor intensive, and the cost of the service for patients who are being weaned often exceeds the present-day payment system under prospective payment. The awardee will evaluate four competitively selected demonstration sites that provide care for chronic ventilator-dependent patients. The evaluation is comprised of three major components: case studies of the demonstration sites, including a comparison of Medicare reimbursement for patient care under the Tax Equity and Fiscal Responsibility Act (TEFRA) compared to reimbursement for the same care under the prospective payment system rules; outcome measures such as the utilization of services, patient health, hospital charges, and Medicare expenditures for individuals admitted to demonstration sites to patients selected to serve as a control group; and estimation of the effects of implementing a national ventilator-dependent unit program, under TEFRA reimbursement, on utilization and Medicare expenditures.

Status: The contract for the evaluation has been modified to increase funding, and the period for preparing the evaluation report has been extended to September 30, 1995. The case study report has been completed. Lewin/VHI is making site visits to collect and analyze data.

91-064 Examination of Alternative Approaches for Graduate Medical Education Payment through Medicare: Continuation of Prior Study

Project No.:	99-C-99168/3
Period:	August 1991–September 1993
Funding:	$ 67,137
Award:	Cooperative Agreement
Principal Investigator:	Dolores Gurnick Clement, Ph.D.
Awardee:	The People-to-People Health Foundation, Inc. (See page 210)
HCFA Project Officer:	Philip G. Cotterill, Ph.D. Division of Payment and Economic Studies

Description: This project is a continuation of a HOPE Research Center project having the same title and project number during the period August 1990 to January 1991. The final report, "A Reexamination of Medicare's Graduate Medical Education (GME) Payment Policy Analysis," provides the background and current provisions for Medicare's payment for GME. The major policy proposals made during 1992–94 for changing GME payments are summarized, and six alternative strategies that could be used to address the issue of Medicare's payment policy for GME are presented. The report also explores what the Health Care Financing Administration can and should do to influence changes in training and reimbursement incentives. An extensive reference list is provided.

Status: This project has been completed. The final report was submitted in August 1994 and is available from the National Technical Information Service, PB95-123527.

93-043 Examination of Alternative Methods for Calculating Relative Values for Practice Expense: The RAND Corporation

Project No.:	500-92-0023DO06
Period:	June 1993–May 1994
Funding:	$ 102,432
Award:	Delivery Order in Master Contract
Principal Investigator:	Eric Latimer, Ph.D.
Awardee:	The RAND Corporation (See page 214)
HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment and Economic Studies

Description: The purposes of this delivery order were to examine alternative methods for determining the practice expense components of the relative value scale for the Medicare fee schedule and to demonstrate the feasibility of using these methods. The first part of this delivery order described exploration of a "service class-practice characteristics" approach to paying physicians for their practice expenses. Under this approach, practice costs that under more traditional accounting methods would be

classified as indirect (e.g., billing, bookkeeping) are directly assigned to cost centers where they can be allocated statistically on the basis of Current Procedural Terminology codes. The second part considered ways to use data obtained directly from physicians to construct Ramsey prices.

Status: This project has been completed. The final report, "Examination of Alternative Methods for Calculating Relative Values for Practice Expense," is available from the National Technical Information Service, accession number PB94-141140.

93-050 Examination of Alternative Methods for Calculating Relative Values for Practice Expense: The University of Minnesota

Project No.:	500-92-0022DO02
Period:	June 1993–June 1995
Funding:	$ 509,740
Award:	Delivery Order in Master Contract
Principal Investigator:	Mark V. Pauly, Ph.D.
Awardee:	The University of Minnesota (See page 214)
HCFA Project Officer:	Edgar A. Peden Ph.D. Division of Payment and Economic Studies

Description: The purposes of this delivery order are to examine alternative methods for determining the practice expense components of the relative value scale for the Medicare fee schedule and to demonstrate the volume and revenue effects of each on a procedure and specialty basis. The current method used to determine practice expense relative values is dictated largely in legislation which requires that they be determined for each procedure or service by specialty from the historic average charges and the practice expense portion of gross revenue. It also takes into account the volume shares for each specialty. Practice expenses do not include the value of the physician's own work related to performing services for patients or malpractice insurance expenses. The Physician Payment Review Commission and some others, including the Harvard Resource-Based Relative Value Scale study team, have expressed a belief that the current method yields irrational results. Others have said that the results yield payments which are as inefficient or even less efficient than those which arose from the former Medicare customary, prevailing, and reasonable physician payment system. This project is the third in a series done by The Leonard Davis Institute of the University of Pennsylvania under subcontract to Minnesota to develop practice cost pricing criteria. Two projects are completed. Two reports are available from the National Technical Information Service: one, "Allocating Practice Costs: Conceptual Issues," accession number PB92-172964, discusses various theories of pricing; the other, "Allocating Practice Costs: Simulations and Other Empirical Work," accession number PB95-103784, uses data to estimate the effects of different pricing schemes. A unique feature of these three projects is that they include a scenario for the efficient allocation of physicians' practice expenses as well as the conceptually simpler methods which look only at covering costs. The purpose of this project is to apply the methodologies developed in the earlier projects to determine practice relative value units on a procedure and specialty basis under at least two scenarios: one based on the economic efficiency criteria seen in Ramsey pricing; the other based on accounting practices.

Status: Pennsylvania researchers have submitted a report detailing the accounting methodology used to assess physicians' practice expenses and are procuring and analyzing data for the analytical part of their task.

IM-005 Financial Ratios: Implications for Assessment of Hospital Profitability and Efficiency

Funding:	Intramural
HCFA Project Director:	William Buczko, Ph.D. Division of Payment and Economic Studies

Description: This project examines the utility of financial ratios for assessment of hospital financial status and compares several ratios measuring aspects of financial performance using Medicare Cost Report data.

Status: Analysis of Medicare patient margin and total facility margin data to assess hospital profitability is ongoing. "Financial Ratios and Hospital Performance," a paper examining several ratios measuring hospital performance, was presented at the 1993 Annual Meeting of the American Public Health Association. Further research will examine additional financial indicators using updated cost report data.

92-035 Geographic Practice Cost Index Assessment and Update

Project No.:	500-89-0050
Period:	April 1992–March 1995
Funding:	$ 643,794
Award:	Contract
Principal Investigator:	Gregory C. Pope, Ph.D.

Awardee:	Health Economics Research, Inc. (HERI) 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Division of Payment and Economic Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: A major change in Medicare physician payment rules encompassing three major elements—replacement of the reasonable charge payment mechanism with a fee schedule for physician services, replacement of the maximum allowable charge limit with new limiting charges, and establishment of national volume performance standards—was implemented on January 1, 1992. The fee schedule, composed of national uniform relative values for physician services, must be adjusted for the cost of medical practice in each Medicare payment locality. This geographic adjustment factor is termed the Medicare geographic practice cost index (GPCI). The purpose of this project is to assess the GPCI, published in Appendix C of the November 25, 1991, *Federal Register* 56(227), as amended in Appendix D of the December 2, 1993, *Federal Register* 58(230), and to update the work, practice expense, and malpractice expense component indexes with 1990 Census and other more recent data. The assessment process will address methodology, proxy data, and new data sources. Weights for the various work, practice expense, and malpractice expense components of the index will be updated with the latest available data. Methodologies will be developed that might be used in future updates of the GPCI.

Status: The 1990 income data from the Census Bureau and the most recent Fair Market Rental (FMR) data from the Department of Housing and Urban Development have been obtained and analyzed. New sources for commercial rental data, including the Internal Revenue Service, the General Services Administration, and the U.S. Postal Service, were explored as possible substitutions for the FMR proxy data. Malpractice premium data for 1990, 1991, and 1992 were collected from an expanded number of underwriters, including physician-owned companies. Physician practice expense weights were updated with more recent American Medical Association socioeconomic data. Reassessment of medical equipment and supplies cost data, transportation cost data, State sales (gross receipts) tax data, commercial rent data, and proxy data have been completed. The calculation of the three component indexes for work, practice expense, and malpractice has been completed and published in the June 24, 1994, *Federal Register* 59(121) Notice of Proposed Rule Making. Transitional GPCIs effective January 1995 and final values effective January 1996 will be published in late fall. The following detailed methodological reports are available from the National Technical Information Service (NTIS):

- "Updating the Geographic Practice Cost Index: Revised Cost Shares," accession number PB94-161072.
- "Updating the Geographic Practice Cost Index: The Physician Work GPCI," accession number PB94-161080.
- "Updating the Geographic Practice Cost Index: The Practice Expense GPCI," accession number PB94-161098.
- "Updating the Geographic Practice Cost Index: The Malpractice GPCI," accession number PB94-161106.

A fifth report, "Comparison of the GPCI Rental Index to Three Sources of Commercial Office Rents," has been received and is being reviewed. Also, public use data tapes are being developed for NTIS submission.

91-074 Hospital Costs, Financial Status, and Market Structure

Project No.:	18-C-90008/1
Period:	September 1991–December 1993
Funding:	$ 291,574
Award:	Cooperative Agreement
Principal Investigator:	Gregory C. Pope, Ph.D.
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Philip G. Cotterill, Ph.D. Division of Payment and Economic Studies
Mandate:	Social Security Amendments of 1983 (Public Law 98-21)

Description: The purpose of this project is to examine the factors associated with inpatient hospital cost increases under Medicare's prospective payment system (PPS) from 1983 through 1992. The project is composed of four self-contained, but related, studies:

- Analysis of the role of procedure intensity in explaining hospital cost increases and cross-sectional differences in hospital costs.
- Examination of the changing mix of Medicare cases treated by hospitals to test for greater regionalization of care post-PPS.

- Decomposition of trends in hospital costs at the departmental level showing the rate of cost inflation among nursing, ancillary, and overhead cost centers.
- Analysis of the relationship between changes in hospital revenues and costs over the post-PPS period.

Status: The final report, "Hospital Costs, Financial Status, and Market Structure," was submitted to the Health Care Financing Administration in August 1994 and is available from the National Technical Information Service, accession number PB95-123535. The following are major findings described in the report. PPS was expected to slow, and possibly even reverse, the rate at which new technologies were incorporated into patient care. However, utilization rates for a wide range of diagnostic and therapeutic procedures were higher in 1990 than in 1985. For example, bypass surgery and PTCA (invasive cardiography) increased twofold to sixfold in the treatment of Medicare patients suffering heart attacks. The cost of treating heart attacks among Medicare patients increased 19 percent in the 5 year period, in large part because of the application of new surgical techniques. It is often assumed that the driving force behind hospital intensity growth in the 1980s has been the diffusion of high-tech services. While this is true to a large extent, it was surprising to find continued growth in low-tech service intensity as well. Routine chest x rays rose nearly 30 percent between 1985 and 1990 for Medicare patients suffering from heart attacks or heart failure. Also, electrocardiogram rates increased 25 percent for these two conditions. The average ancillary cost per discharge, adjusted for outpatient activity (but not inflation), more than doubled between 1983 and 1992. The surgical service and the pharmacy were the leading growth centers, directly accounting for one-third of the cost growth among the 20 ancillary departments. The high rate of growth in ancillary departments was the result of greater labor intensity per discharge. For example, the number of full-time equivalent staff hours in the operating room per adjusted discharge grew 8.5 percent per year between 1988 and 1992. The medical care sector has been cited as an example of the high rate of technical obsolescence. Long before the first generation technology is diffused across the industry, a second, and sometimes a third generation begins to diffuse among large teaching hospitals. Magnetic resonance imaging (MRI) is one well-known example, and ultrasound is another. The original M-mode machines are being replaced with faster machines showing multiple dimensions and others that monitor blood flows as well. In addition, often partially substitutable technologies continue to diffuse at the same time. For example, in elderly stroke patients, computerized tomography brain scans in the average hospital increased by about one-third between 1985 and 1990, while MRI brain scans and cerebral angiography also were increasing rapidly. High-cost hospitals also provide more intensive care than do lower cost hospitals. For example, in 1990 the highest cost hospitals performed 2D cardiac echocardiography on 437 of every 1,000 patients. The rate for average cost hospitals was 358 per 1,000 patients. Highest cost hospitals performed coronary angiography at a rate of 49 per 1,000 patients, compared to a rate of 30 per 1,000 patients in average cost hospitals. Heart bypass rates were about one-third higher in high-cost hospitals compared to average cost hospitals.

91-076 Hospital Market Dynamics and the Adoption of Expensive Medical Technology

Project No.:	17-C-90010/4
Period:	September 1991–September 1994
Funding:	$ 199,247
Award:	Cooperative Agreement
Principal Investigator:	Thomas J. Hoerger, Ph.D.
Awardee:	Health Policy Center Vanderbilt University Box 1503–Station B Nashville, TN 37235
HCFA Project Officer:	Alvin L. Freedman Division of Payment and Economic Studies

Description: The project will study the interaction between hospital competition and the adoption of expensive medical technologies. The objectives are: to provide a better understanding of the interrelationships among hospital competition, reimbursement policy, and the adoption of expensive technologies; to analyze the effects of technology on hospital market structure; and to study how new technologies diffuse across diagnoses and from inpatient to outpatient services. The study will focus on technology adoption by hospitals in California, Florida, and Tennessee.

Status: Refinements have been made in a series of conceptual models developed to explain how hospitals compete by investing in outpatient capacity to attract physicians and their patients. Data have been assembled and are being analyzed. The project was granted an additional extension through September 30, 1994.

91-079 **Hospital Medical Staff Volume Performance Standards** (Formerly, Development of Hospital Medical Staff Volume Performance Standards)

Project No.:	18-C-90038/3
Period:	September 1991–September 1994
Funding:	$ 646,002
Award:	Cooperative Agreement
Principal Investigator:	W. Pete Welch, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Teresa L. DeCaro Division of Payment and Economic Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: This project explores the hospital medical staff as a risk pool of physicians, distinguishable from the national pool to which the Medicare volume performance standards (MVPS) currently apply. Three payment alternatives targeted at medical staffs were explored in a prior study (17-C-99489/3), including separate MVPS, lump-sum prospective payment, and a withhold for high-cost medical staffs. Four major initiatives in the current study include:

- Updating the case-mix index based on diagnostic-related groups to reflect relative value units (RVU) rather than allowed charges.
- Analyzing the stability of case-mix-adjusted RVUs per admission across a representative sample of hospital medical staffs and over time.
- Developing a physician profiling tool for hospital episodes.
- Investigating the relationship between Part B physician and Part A inpatient hospital costs.

Status: The high-cost medical staff model developed under this study lays the foundation for a Medicare cost containment strategy presented in several health care reform legislative proposals including the Health Security Act (HSA). This policy option would operate under the national MVPS. The model withholds a portion of each Part B physician payment made to physicians only when the service is provided in association with a hospital stay and the hospital's medical staff has an average annual per admission volume above a national threshold. Each medical staff's performance status for a target year—high cost or not—is determined by measuring a prior year's average case-mix-adjusted RVUs per admission, and comparing it to the national average. For staffs subjected to a withhold during the target year, all or a portion is refunded in a future year if actual performance in the target year proves to be below the high-cost threshold. This process is repeated annually. This option is described in two reports available from the National Technical Information Service (NTIS) and a professional journal:

- "Medical Staff Risk Pool Policies: Stability and Simulation," accession number PB94-203262.
- "High Cost Hospital Medical Staff Proposal in the Health Security Act (HSA): Distributional Impacts," accession number PB94-203254.
- Welch, W.P., and Miller, M.E.: High-Cost Medical Staffs: Proposals to Control High-Cost Hospital Medical Staff. *Health Affairs*, 13(4):42–57, Fall 1994.

The "Stability and Simulation" report describes optional model parameters and presents stability and simulation analyses. Findings include that the change in level from year to year of a medical staff's average case-mix-adjusted utilization per admission is sufficiently stable to support this type of policy. The "Distributional Impacts" report describes the HSA legislative proposal, presents simulated impacts by State and type of hospital, and suggests alternative refinements to the proposal. Findings suggest that several States would be significantly, adversely affected. Refinements could be incorporated to reduce this effect, but would also tend to lower Medicare's cost savings. The *Health Affairs* article features the policy parameters proposed in the HSA, and discusses technical and policy refinements such as transitioning, multi-level thresholds, truncating data to protect providers from risk associated with outliers, and the role of profiling to protect quality of care under this type of cost containment initiative. Also available from NTIS and a professional journal are the following: "Physician Hospital Privileges: Implications for a Medical Staff Policy," accession number PB94-168333, reports on physician affiliation and the plausibility of physicians shifting admissions away from high-cost hospital staffs to other hospital staffs with whom they are affiliated. Findings include that Medicare attending physicians average 1.56 affiliations, and on average physicians have 90 percent of their admissions in a single hospital. It concludes that in the short run physicians are unlikely to shift admissions and that market pressures in the long term would make it more unlikely. "Toward Profiling Physicians for Inpatient Services: Florida," accession number PB94-109808; and Welch, H.G., Miller, M.E., and Welch, W.P.: Analysis of Inpatient Practice Patterns in Florida and Oregon. *New England Journal of Medicine*, 607-612, March 3, 1994, relate to the profiling task under this project. A prototype profiling

tool was developed that dissects medical staffs' case-mix-adjusted inpatient utilization to assist medical staffs in understanding their practice patterns. The report on Florida describes the technical aspects of the profiling tool and reports patterns for medical staffs in Florida by metropolitan statistical area and at the individual hospital-level, by type of service and type of physician specialty. The journal article finds inpatient practice styles of Florida physicians markedly more resource intensive than that of Oregon physicians. The difference is apparent across all specialties and all service types. "Analysis of Hospital Medical Staff Volume Performance Standards: Technical Report," accession number PB93-181964, describes and analyzes the modeling of utilization measurements that occurred early in the project. A draft report on the relationship between Part B physician RVUs and Part A inpatient hospital costs at the individual hospital level is under review, as is the draft final report for the project.

94-112 **Implementation and Evaluation of Ambulatory Patient Groups as an Outpatient Measurement and Financing Methodology in Maine**

Project No.:	18-C-90410/1
Period:	September 1994–September 1996
Funding:	$ 263,300
Award:	Cooperative Agreement
Principal Investigator:	Amanda Attridge
Awardee:	State of Maine State House Station 102 9 Green Street Augusta, ME 04333
HCFA Project Officer:	Joseph M. Cramer Division of Hospital Experimentation

Description: The project will establish a comprehensive all-payer outpatient data base and will implement ambulatory patient groups (APG) as an outpatient measurement and financing methodology in Maine. The project will develop a comprehensive data base for all hospital outpatient services that can be used in health care policy, planning, research, and regulation. The project will provide the results of Maine's experience in the implementation of APGs and an evaluation of their potential to control health care costs.

Status: The project is in the early developmental stage.

94-090 **Improving Measurement of Hospital Output**

Project No.:	17-C-90447/9
Period:	September 1994–November 1995
Funding:	$ 285,924
Award:	Cooperative Agreement
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Payment and Economic Studies

Description: The purpose of this project is to explore the policy implications of an improved way of measuring hospital output by combining the diagnosis-related group system for classifying discharges with the California standard measurement unit system for measuring the intensity of care per case-mix constant discharge. The project will estimate the annual change in California hospital output and compare this estimate with the method currently used by the Health Care Financing Administration. In addition, the project will analyze the extent to which case-mix constant intensity determines differences in cost among hospital groups. Since measures of hospital output are critical for the prospective payment system, the results of this project will help to validate current policies including the annual update and other adjustment factors.

Status: This project is in the early developmental stage.

94-102 **Levels and Determinants of Hospital Inefficiency**

Project No.:	17-C-90285/4
Period:	September 1994–September 1995
Funding:	$ 146,042
Award:	Cooperative Agreement
Principal Investigator:	Alan M. Sear
Awardee:	University of South Florida 4202 Fowler Avenue Tampa, FL 33620
HCFA Project Officer:	Edgar A. Peden Division of Payment and Economic Studies

Description: The principal objective of this project is to quantify current levels and historical rates of change in hospital inefficiency. A set of statistical analyses, including data envelopment analysis and frontier cost analysis, will draw on longitudinal information about hospitals in the State of Florida to accomplish this goal. As part of this analysis, the project will identify the

determinants of the level and changes in inefficiency, both within hospitals (e.g., organizational characteristics, arrangements with the medical staff, practice patterns) and those in the external environment to hospitals (e.g., the degree of competition in the local health care market, regulations, technological diffusion). Finally, it will prepare a set of policy recommendations based on the empirical findings that emphasize how hospital management practices and/or external market characteristics might be shaped by Federal policymakers to further reduce hospital inflation.

Status: This project is in the early developmental stage.

94-110 Maine Medicare Volume Performance Standard Demonstration Project

Project No.:	19-C-90401/1
Period:	September 1994–September 1997
Funding:	$ 341,750
Award:	Cooperative Agreement
Principal Investigator:	Robert B. Keller, M.D.
Awardee:	Maine Medical Assessment Foundation P.O. Box 4682 Augusta, ME 04330-1682
HCFA Project Officer:	Mark A. Krause, Ph.D. Division of Hospital Experimentation

Description: This research will assess the feasibility and value of a State-level Medicare volume performance standard (MVPS). Among other individuals, analysts at the Physician Payment Review Commission have raised questions regarding the effectiveness of the current national volume performance standard methodology. These analysts have argued that the current MVPS program may not be accomplishing its intended goal of providing an incentive for physicians to avoid excessive increases in the volume of services they furnish to Medicare beneficiaries. The Maine Medical Assessment Foundation (MMAF) in conjunction with the Urban Institute will analyze national and State-level physician data to provide information about the volume (rate) and intensity (relative value units) of medical services provided to Medicare beneficiaries in the State of Maine. MMAF will utilize these data to create analytic files and reports on population-based utilization rates of services and the intensity of those services. Data will be provided to 10 specialty study groups. This information will be used by physicians to change their practice behaviors by improving the efficiency and appropriateness of the care they provide. Access and quality of care will be monitored closely by an advisory committee, and all aspects and implications of the project will be evaluated by the project staff and an external reviewer.

Status: The project is in the early development stage.

IM-008 Malpractice Component of the Medicare Economic Index

Funding:	Intramural
HCFA Project Director:	Benson L. Dutton Division of Payment and Economic Studies
Mandate:	Social Security Amendments of 1972 (Public Law 92-603)

Description: Each year since 1975, the Health Care Financing Administration (HCFA) publishes the Medicare Economic Index (MEI), which was first mandated by Congress in Public Law 92-603 for use in establishing reasonable charges for physician services. Since 1992, the MEI has been used as a key factor in determining the Medicare fee schedule's annual conversion factor update pursuant to section 6102(a) of Public Law 101-239. The MEI is developed by HCFA's Office of the Actuary in accordance with the basic methodology set forth in 42 *Code of Federal Regulations* 405.504(a)(3)(i) and 405.504(d) from selected components of the Consumer Price Index and the Producer Price Index, plus estimates of the annual changes in medical malpractice premiums for specific levels of coverage. HCFA's Office of Research and Demonstrations collects data for calculating the malpractice component of the MEI annually from major medical malpractice insurers. For several periods beginning January 1, 1987, the MEI increase has been established by Congress through section 9331(c)(i) of Public Law 99-509 for Fee Screen Year (FSY) 1987, and section 4041(a) of Public Law 100-203 for the first 3 months of FSY 1988, and section 4042(b)(4)(F)(iii) for FSY 1989, and section 4105(a) of Public Law 101-508 for FSY 1991 and FSY 1992. Again, for FSY 1994 and FSY 1995, changes in the physician fee schedule conversion factor and the Medicare volume performance standards update factor were established under sections 13511 and 13512 of Public Law 103-66 respectively.

Status: The requisite data for updating the medical malpractice component of the MEI have been obtained and results provided to HCFA's Office of the Actuary. Announcement of the next MEI will be made in the *Federal Register* for FSY 1995 (January 1, 1995 to December 31, 1995).

92-002 **Measurement of Outpatient Facility Resource Costs**

Project No.:	18-C-90123/3
Period:	October 1991–March 1994
Funding:	$ 771,028
Award:	Cooperative Agreement
Principal Investigator:	Henry Miller, Ph.D.
Awardee:	Center for Health Policy Studies 9700 Patuxent Woods Drive Columbia, MD 21046
HCFA Project Officer:	Michael Henesch Division of Hospital Experimentation

Description: The implementation of an outpatient prospective payment system (PPS) by the Health Care Financing Administration (HCFA) will require a thorough knowledge of costs of outpatient services. The primary purpose of this study is to study outpatient facility resource costs that can be used as background to formulate an outpatient PPS. Implementation of an outpatient PPS system requires a thorough knowledge of the costs of outpatient services so that payment rates reflect resource use. To meet the need for more accurate resource measures, this study will measure resource use and resource costs for a variety of outpatient procedures and visits. The study then may be used to assess equity and the adequacy of relative weights for an outpatient PPS system. The approach of the study is to focus on the resource costs of procedures as they are categorized in the ambulatory patient group (APG) patient classification system. All APG categories are being studied, including surgery, medical diagnoses, and ancillary tests. The study will analyze facility costs and will not consider physician costs. In addition to providing procedure/service-specific resource costs for a large number of procedures/services, this study will:

- Identify direct and indirect costs by type for each procedure/service.
- Identify differences in resource use and unit costs on a procedure/service-specific basis across settings, i.e., hospital outpatient departments, ambulatory surgical centers (ASC), and physicians' offices.
- Identify marginal costs of procedures when two or more procedures are performed at the same time.
- Compare procedure/service-specific resource costs to other procedure/service-specific values, including charges and current payment levels.
- Compare aggregate resource costs to aggregate outpatient costs reported in Medicare Cost Reports and other sources of cost data.

Status: The project began in October 1991 with the development of resource use costing models and the preparation of the study's research design. Four models (surgery, medical, radiology, and laboratory) were developed to reflect the requirements for specific services. Development of resource use and cost tables also was initiated during the early part of the study and will continue during the course of the project. A sample of hospitals, ASCs, and physician offices was visited to gather data. Efforts were devoted to assuring the representativeness of the sample sites that were selected. A large number of procedures/visits were selected for data collection and analysis covering resource costs for ambulatory surgery, radiology, pathology, and medical services. As data are collected, a relational data base is being prepared and maintained. This will assure HCFA that the data collected for this study will be available for use beyond the study's findings. In addition to collecting general information, data collectors have asked clinical staff to validate resource use profiles for all procedures performed at the facility. Data collectors also have met with finance personnel to obtain costs of all resources listed in the profiles. The data collection effort has been completed. The clinical advisory panel will meet to review the results of the study. The final report is expected in fall 1994.

89-005 **Medicare Cataract Surgery Alternate Payment Demonstration**

Project No.:	500-87-0030TO06
Period:	June 1989–June 1994
Funding:	$ 1,005,345
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Monica Noether, Ph.D.
Awardee:	Abt Associates Inc. (See page 216)
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: The objective of the task is to assist the Health Care Financing Administration (HCFA) in the design, implementation, and evaluation of a demonstration to assess the feasibility of a negotiated all-inclusive price concept for cataract surgery. The negotiated price covering physician, facility, and intraocular lens costs for the procedure is being tested at three sites. Participation by providers and beneficiaries at each site is completely voluntary.

Status: In late 1992, HCFA completed its evaluation of the final applications received from providers in three

sites: Cleveland, Ohio; Dallas/Fort Worth, Texas; and Phoenix, Arizona. The evaluation process involved recommendations from final application review panelists, price negotiations, site visits, and internal quality review procedures. HCFA executed provider agreements with three organizations in Cleveland, one in Dallas/Fort Worth, and one in Phoenix. After a brief developmental period, four of the five organizations began providing services under the demonstration in April 1993 while one site in Cleveland withdrew from the project. The contract terminated in July 1994, but Abt Associates is continuing the evaluation activities under Contract No. 500-94-0038, entitled Monitoring and Evaluation of the Medicare Cataract Surgery Alternate Payment Demonstration.

93-084 **Medicare-Designated Cataract Surgery Providers: Cataract Eye Center of Cleveland, Inc.** (Formerly, Medicare Designated Cataract Surgery Providers)

Project No.:	95-P-30005/5
Period:	January 1993–April 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Samuel M. Salamon, M.D.
Awardee:	Cataract Eye Center of Cleveland, Inc. 2322 East 22nd Street, Suite 307 Cleveland, OH 44115
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: This physician group practice in Ohio is one of four sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive price concept for cataract surgery. The negotiated price covering physician, facility, and intraocular lens costs for the procedure is being tested in three metropolitan statistical areas: Cleveland, Ohio; Dallas/Fort Worth, Texas; and Phoenix, Arizona. Participation by providers and beneficiaries at each site is completely voluntary.

Status: In April 1993, this site successfully implemented the 3-year demonstration.

93-082 **Medicare-Designated Cataract Surgery Providers: Medical Eye Associates, Inc.** (Formerly, Medicare Designated Cataract Surgery Providers)

Project No.:	95-P-30002/5
Period:	January 1993–April 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Boris Komrovsky, M.D.
Awardee:	Medical Eye Associates, Inc. 7003 Pearl Road Middleburg Heights, OH 44130
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: This physician group practice in Ohio is one of four sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive price concept for cataract surgery. The negotiated price covering physician, facility, and intraocular lens costs for the procedure is being tested in three metropolitan statistical areas: Cleveland, Ohio; Dallas/Fort Worth, Texas; and Phoenix, Arizona. Participation by providers and beneficiaries at each site is completely voluntary.

Status: In April 1993, this site successfully implemented the 3-year demonstration.

93-081 **Medicare-Designated Cataract Surgery Providers: National Medical Enterprises** (Formerly Medicare Designated Cataract Surgery Providers)

Project No.:	95-P-30001/6
Period:	January 1993–April 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Reynold J. Jennings
Awardee:	National Medical Enterprises Doctors Hospital of Dallas 9440 Poppy Drive Dallas, TX 75218
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: This hospital in Texas is one of four sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive price concept for cataract surgery. The negotiated price covering physician, facility, and intraocular lens costs for the procedure is being tested in three metropolitan statistical areas: Cleveland, Ohio; Dallas/Fort Worth, Texas; and Phoenix, Arizona. Participation by providers and beneficiaries at each site is completely voluntary.

Status: In April 1993, this site successfully implemented the 3-year demonstration.

93-083 **Medicare-Designated Cataract Surgery Providers: Southwestern Eye Center, Ltd.** (Formerly, Medicare Designated Cataract Surgery Providers)

Project No.:	95-P-30003/9
Period:	January 1993–April 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	L. Lothaire Bluth, M.D.
Awardee:	Southwestern Eye Center, Ltd. 1818 East Southern Avenue, Suite 18 Mesa, AZ 85204
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: This ambulatory surgery center in Arizona is one of four sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive price concept for cataract surgery. The negotiated price covering physician, facility, and intraocular lens costs for the procedure is being tested in three metropolitan statistical areas: Cleveland, Ohio; Dallas/Fort Worth, Texas; and Phoenix, Arizona. Participation by providers and beneficiaries at each site is completely voluntary.

Status: In April 1993, this site successfully implemented the 3-year demonstration.

92-038 **Medicare Fee Schedule Refinement**

Project No.:	500-92-0025
Period:	June 1992–June 1993
Funding:	$ 585,922
Award:	Contract
Principal Investigator:	William C. Hsiao, Ph.D.
Awardee:	President and Fellows of Harvard College Harvard School of Public Health 1350 Massachusetts Avenue Holyoke Center, 4th Floor Cambridge, MA 02138
HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment and Economic Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: The purpose of this contract was to provide information to the Health Care Financing Administration that could be used in revising the Medicare fee schedule (MFS). Specifically, this contract had these tasks:

- Validate specialty-specific examples for evaluation and management services that are included in the MFS, but are performed by specialties that are not included under the umbrella of the American Medical Association.
- Determine relative work values for specific psychological tests.
- Validate time components of work for reference procedures of the MFS.
- Develop relative work values for procedures that were identified in the MFS as being paid "by report."
- Determine the magnitude of economies of scope in the provision of bilateral and surgical procedures.

Status: The final report, "A National Study of Resource-Based Relative Values for Physician Services: Medicare Fee Schedule Refinement," is available from the National Technical Information Service, accession number PB94-115094. For the associated computer disk, the accession number is PB94-500634. For the computer documentation only, the accession number is PB94-104759.

89-006 **Medicare Participating Heart Bypass Center Demonstration**

Project No.:	500-87-0029TO04
Period:	June 1989–December 1994
Funding:	$ 969,662
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Robert J. Rubin, M.D.
Awardee:	Lewin/VHI, Inc. (See page 216)
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: The awardee's objective is to assist the Health Care Financing Administration (HCFA) in implementing and evaluating a 3-year demonstration designed to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft surgery while maintaining high quality care. Lewin/VHI will assist HCFA in preparing an evaluation and implementation plan, monitoring the demonstration sites, collecting and analyzing data, and preparing the final evaluation report. Some key questions to be addressed during the evaluation are:

- Did the demonstration result in a net cost savings to the Medicare program?

- What was the source of any volume increases at the demonstration sites?
- What aspects of a demonstration site are attractive to Medicare beneficiaries and to referring physicians?
- Was the quality of care at the demonstration sites equivalent to that provided at the sites prior to the demonstration?

Status: HCFA negotiated with the finalists and selected four demonstration sites in January 1991. Implementation of the demonstration began in May 1991. Lewin/VHI completed the design of the evaluation and began data collection at the sites. In December 1992, HCFA expanded the demonstration to include three additional sites from among the remaining six recommended hospitals bringing the total number of demonstration sites to seven. These additional sites began service delivery under the demonstration in May and June 1993. In September 1993, the evaluation contract with Lewin/VHI was modified to include the three new sites. The final evaluation report from Lewin/VHI on the first 3 years of the demonstration is expected in December 1994.

94-010 Medicare Participating Heart Bypass Center Demonstration Extended Evaluation

Project No.:	500-92-0013DO03
Period:	July 1994–February 1997
Funding:	$ 363,318
Award:	Delivery Order in Master Contract
Principal Investigator:	Jerry Cromwell, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) (See page 207)
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: The awardee's objective is to assist the Health Care Financing Administration (HCFA) in the continued evaluation of a 5-year extended demonstration designed to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft surgery while maintaining high quality care. Health Economics Research, Inc. (HERI), will assist HCFA by continuing the demonstration evaluation plan established under a previous contract, by monitoring the demonstration sites, by collecting and analyzing data, and by preparing the final evaluation report. Some key questions to be addressed during the evaluation are:

- Did the demonstration result in a net cost savings to the Medicare program?
- What was the source of any volume increases at the demonstration sites?
- What aspects of a demonstration site are attractive to Medicare beneficiaries and to referring physicians?
- Was the quality of care at the demonstration sites equivalent to that provided at the sites prior to the demonstration?

Status: HCFA negotiated with the finalists and selected four demonstration sites in January 1991. Implementation of the demonstration at three sites began in May 1991. In December 1992, HCFA expanded the demonstration to include three additional sites from among the remaining six recommended hospitals, bringing the total number of demonstration sites to seven. These additional sites began service delivery under the demonstration in May and June 1993. In spring 1994, at their request, the first four sites were allowed to continue under the demonstration for an additional 2 years. In June 1994, a new evaluation contract was awarded to HERI to extend the evaluation of the seven sites for the remainder of their participation. The final evaluation report is expected in February 1997.

91-006 Medicare Participating Heart Bypass Center Demonstration: Georgia (Formerly, Medicare Participating Heart Bypass Centers)

Project No.:	95-P-99602/4
Period:	January 1991–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Susan White
Awardee:	Saint Joseph's Hospital of Atlanta 5665 Peachtree Dunwoody Road, NE. Atlanta, GA 30342-1701
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: This hospital in Georgia is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital, successfully ending its 3-year participation in spring 1994, requested and received a

2-year continuation under the demonstration until June 30, 1996.

93-011 **Medicare Participating Heart Bypass Center Demonstration: Indiana** (Formerly, Medicare Participating Heart Bypass Centers)

Project No.:	95-P-99599/5
Period:	January 1993–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Stephen J. Jay, M.D.
Awardee:	Methodist Hospital of Indiana, Inc. 1701 North Senate Boulevard Indianapolis, IN 46206-1367
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: This hospital in Indiana is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital successfully implemented the 3-year demonstration in spring 1993.

91-003 **Medicare Participating Heart Bypass Center Demonstration: Massachusetts** (Formerly Medicare Participating Heart Bypass Centers)

Project No.:	95-P-99592/1
Period:	January 1991–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Paul Drew
Awardee:	The University Hospital Boston University Medical Center 88 East Newton Street Boston, MA 02118-2393
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: This hospital in Massachusetts is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital, successfully ending its 3-year participation in spring 1994, requested and received a 2-year continuation under the demonstration until June 30, 1996.

91-004 **Medicare Participating Heart Bypass Center Demonstration: Michigan** (Formerly, Medicare Participating Heart Bypass Centers)

Project No.:	95-P-99591/5
Period:	January 1991–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Richard Prager, M.D.
Awardee:	Catherine McAuley Health System 5301 East Huron River Drive Ann Arbor, MI 48106
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: This hospital in Michigan is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital, successfully ending its 3-year participation in spring 1994, requested and received a 2-year continuation under the demonstration until June 30, 1996.

91-005 **Medicare Participating Heart Bypass Center Demonstration: Ohio** (Formerly, Medicare Participating Heart Bypass Centers)

Project No.:	95-P-99597/5
Period:	January 1991–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Kamilla K. Sigafoos
Awardee:	The Ohio State University Hospitals 450 West 10th Avenue Columbus, OH 43210-1228
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: This hospital in Ohio is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital, successfully ending its 3-year participation in spring 1994, requested and received a 2-year continuation under the demonstration until June 30, 1996.

93-010 **Medicare Participating Heart Bypass Center Demonstration: Oregon** (Formerly, Medicare Participating Heart Bypass Centers)

Project No.:	95-P-99604/0
Period:	January 1993–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	John V. Fletcher
Awardee:	St. Vincent Hospital and Medical Center 9155 SW. Barnes Road Portland, OR 97225
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: This hospital in Oregon is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital successfully implemented the 3-year demonstration in spring 1993.

93-012 **Medicare Participating Heart Bypass Center Demonstration: Texas** (Formerly, Medicare Participating Heart Bypass Centers)

Project No.:	95-P-99603/6
Period:	January 1993–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Michael D. Israel
Awardee:	St. Luke's Episcopal Hospital Texas Medical Center 6720 Bertner Street Houston, TX 77030
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: This hospital in Texas is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital successfully implemented the 3-year demonstration in spring 1993.

94-011 **Medicare Preferred Provider Organization**

Project No.:	500-92-0011DO05
Period:	July 1994–August 1995
Funding:	$ 226,465
Award:	Delivery Order in Master Contract

Principal Investigator:	Merrile Sing, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 208)
HCFA Project Officer:	Victor G. McVicker Division of Hospital Experimentation

Description: The purpose of this delivery order is to assess the feasibility of adopting for the Medicare program one or more of the innovative, cost-effective health delivery approaches that have developed in the private sector. The approaches under consideration include, but are not limited to, preferred provider organizations, point-of-service plans, and bundled payments for certain high-cost/high-volume procedures. The awardee also will develop an implementation plan for a demonstration of one or more of the systems that appear most promising.

Status: This project is in the early developmental stage.

92-003 Medicare Volume Performance Standards for Voluntary Physician Organizations

Project No.:	17-C-90129/1
Period:	October 1991-December 1994
Funding:	$ 846,356
Award:	Cooperative Agreement
Principal Investigator:	Christopher P. Tompkins, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Teresa L. DeCaro Division of Payment and Economic Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: This project is an extension of a prior study (99-C-98526/1) that explored the cross-sectional and longitudinal volume and intensity of Medicare service utilization by physician group practice characteristics. The final report for that study, "Setting Medicare Volume Performance Standards for Large Primary Care Medical Practices," accession number PB93-190353, is available from the National Technical Information Service. Per beneficiary utilization patterns were measured under three different service definitions including: physician services provided by the group practice only, all physician services covered under the Medicare volume performance standards (MVPS), and all Medicare-covered services. The most stable service definition—average total MVPS service reimbursements provided to a unique patient (RPUP) seen by the practice—had a mean absolute percent error (MAPE) of 10.9 percent. The current study seeks to design payment policy options that would provide incentives for qualified physician practices in the fee-for-service sector to seek administrative and clinical decisionmaking efficiencies under the national MVPS.

Status: This project involves calculating RPUPs and MAPEs for the same (or similar) service definitions used in the prior study, but in a significantly improved data environment also with better case-mix adjustment, to assure sufficient data stability to support the policy options under consideration. Case studies and data envelopment analysis involving 10 multispecialty group practices and their market areas will be used to characterize "best practices," to develop criteria for participation, and to understand policy, market and administrative conditions that would encourage participation. An interim draft report has been submitted describing a basic group practice volume performance standard model and its optional technical and policy parameters. Pending interim reports include one that discusses the conceptual framework about the environment and organizational influences on physician behavior, and one that shows preliminary findings from analysis of a pilot sample that predates the full study file construction now in its final stage of completion.

91-040 Methods for Tracking Volume/Intensity Change

Project No.:	99-C-98526/1
Period:	August 1991–January 1993
Funding:	$ 117,028
Award:	Cooperative Agreement
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Brandeis University (See page 202)
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Division of Payment and Economic Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: For this project, researchers at the Center for Health Economics Research used the Health Care Financing Administration's new Access to the National

Claims History Repository system software and 1991 National Claims History data to monitor Medicare service utilization and expenditures. Episodes of care were constructed from Parts A and B claims data and enrollment files for two high-volume medical conditions—acute myocardial infarction and chronic obstructive pulmonary disease, and one high-volume surgical procedure—coronary artery bypass graft. For each index admission to a hospital, a time window was constructed to define pre-admission, admission, and post-admission periods service utilization. The episodes data permitted indepth description of beneficiary characteristics and their volume and service intensity while holding case mix constant.

Status: This project has been completed. A final report, "Methods for Tracking Volume/Intensity Change," accession number PB94-122868, is available from the National Technical Information Service.

94-130 Monitoring and Evaluation of the Medicare Cataract Surgery Alternate Payment Demonstration

Project No.:	500-94-0038
Period:	August 1994–August 1996
Funding:	$ 496,049
Award:	Contract
Principal Investigator:	Monica Noether, Ph.D.
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: The objective of this contract is to assist the Health Care Financing Administration in the monitoring and evaluation of a demonstration to assess the feasibility of an all-inclusive negotiated price concept for cataract surgery. The evaluation will be conducted under a revised plan using the Johns Hopkins University Cataract Patient Outcome Research Team data base in place of control site data. The negotiated price covering physician, facility, and intraocular lens costs for the procedure is being tested at four sites in three metropolitan statistical areas. Participation by providers and beneficiaries at each site is completely voluntary. Some key questions to be addressed during the evaluation are:

- Did the demonstration result in a net cost savings to the Medicare program?
- What is the change over time in the use of services included and the use of services excluded from the bundle?
- How satisfied are beneficiaries with cataract surgery provided under a demonstration-bundled rate compared to patients undergoing cataract surgery paid for according to traditional Medicare principles?
- Did the quality of care at the demonstration sites change from the care provided at the same sites prior to the demonstration?

Status: An interim report based on the first year's data is expected to be completed in summer 1995. The final report is expected in late spring 1996.

93-067 Negotiated Surgical Episode Package Price Options for Services Within an Episode of Care: Feasibility and Strategy for Implementation under the Medicare Program

Project No.:	500-92-0014DO03
Period:	September 1993–January 1995
Funding:	$ 345,661
Award:	Delivery Order in Master Contract
Principal Investigator:	Gary Gaumer, Ph.D.
Awardee:	Abt Associates Inc. (See page 206)
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Hospital Experimentation

Description: The purpose of this study is to provide the Health Care Financing Administration with a practical strategy for formulating and implementing a program policy for negotiated surgical episode package price options under the Medicare program. Two or three surgical episode package price options that could be implemented under the proposed strategy also will be identified and assessed.

Status: The final report is expected in January 1995.

94-093 Physician Capitation for Medicare Services: Feasibility Study and Demonstration Design

Project No.:	500-92-0011DO04
Period:	January 1994–June 1995
Funding:	$ 284,541
Award:	Delivery Order in Master Contract
Principal Investigator:	Lyle Nelson, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 208)
HCFA Project Officer:	Edward T. Hutton, Ph.D. Division of Health Systems and Special Studies

Description: The purposes of this contract are to assess the feasibility and to propose design(s) for a potential demonstration initiative for: making a capitated payment to physician groups for Medicare Parts A and B services and making a "bundled" payment to physicians for some subset of Part B services. The intent is to reduce Medicare's administrative costs and to lessen the burden imposed on the Medicare program, and on physicians and beneficiaries, and to promote efficiency in health service delivery by giving physicians a single payment that will cover a variety of services, some of which may be provided by other health care providers. The awardee will build on the Health Care Financing Administration's (HCFA) previous work in regard to capitated and bundled payment for physician services, analyze HCFA data to explore additional methods for clustering and setting rates for subsets of Part B services, and develop research designs and implementation strategies for potential demonstrations.

Status: Meeting with industry, State insurance regulators, and Federal Government have resulted in information useful for assessing the feasibility and design of the demonstration. Data files have been built and data analysis has started.

89-002 **Physician Preferred Provider Organization Demonstration Sites: California** (Formerly, Physician Preferred Provider Organization Demonstration Sites)

Project No.:	95-C-99340/9
Period:	January 1989–February 1994
Funding:	$ 5,409,778
Award:	Cooperative Agreement
Principal Investigator:	Edward Zalta, M.D.
Awardee:	CAPP CARE, Inc. West Tower 4000 MacArthur Boulevard, Suite 10000 Newport Beach, CA 92660-2526
HCFA Project Officer:	Victor G. McVicker Division of Hospital Experimentation

Description: CAPP CARE is a for-profit preferred provider organization (PPO) physician network operating in 34 States. It is one of five PPO demonstration sites selected for the Medicare physician PPO pilot demonstration. This demonstration was implemented for a 4-year period beginning on March 1, 1990, and is being conducted in Orange County, California, as a nonenrollment model that allows any Medicare beneficiary in the service area to use CAPP CARE physicians at any time. Beneficiaries who receive services from CAPP CARE physicians participating in the demonstration are assured that those physicians will accept Medicare payments as payment in full. The purpose of this project is to evaluate the performance of physicians via utilization review, medical review, and quality assurance protocols, and to assess the impact on the Medicare program. The analysis will include prior authorization of all elective admissions and procedures, both inpatient and outpatient, and retrospective review based on paid claims data run against an automated ambulatory care review system.

Status: At the close of the fourth and final year of operation, the Medicare provider network had 917 physicians. The CAPP CARE demonstration physicians were generating about 800 precertification requests per month. The number of claims received by CAPP CARE for this year was about 500,000 per month. The demonstration ended on February 28, 1994, and the final report has been received.

89-003 **Physician Preferred Provider Organization Demonstration Sites: Minnesota** (Formerly, Physician Preferred Provider Organization Demonstration Sites)

Project No.:	95-C-99346/5
Period:	January 1989–December 1994
Funding:	$ 586,827
Award:	Cooperative Agreement
Principal Investigator:	M. Nazie Eftekhari
Awardee:	The Araz Group 8500 Normandale Lake Boulevard Suite 2050 Bloomington, MN 55437
HCFA Project Officer:	Victor G. McVicker Division of Hospital Experimentation

Description: The Araz Group (formerly, Family Health Plan) is one of five preferred provider organization (PPO) sites selected for participation in the Medicare physician PPO pilot demonstration. The Araz Group contracts directly with employers in the Minneapolis/St. Paul area to enroll their employee groups into the PPO. The Araz Group offers a network of cost-effective providers and a claims-based utilization review program to control the volume of service use. The Araz Group's utilization review program includes preadmission certification, retrospective review, outpatient management, and case management. For the Medicare demonstration, the Araz Group is focusing on enrolling Medicare beneficiaries through employer retiree benefit plans. On January 1, 1992, the Araz Group began servicing Medicare beneficiaries under contracts with employer retiree groups.

Status: At the close of the second year of operation, the Araz Group continues to serve the same two employers, Minnegasco and Northwest Airlines. Minnegasco, a local gas utility with about 805 retirees, is self-insured, and the retirees share in the cost of the plan. Northwest Airlines has 201 retirees under the demonstration and is self-insured. The Medicare provider network has increased in size from 425 to 450 physicians. The Araz Group receives about 600 claims per month. The demonstration is scheduled to end on December 31, 1994.

93-051 Prospective Per Case Payment for Episodes of Hospital Care (Formerly, Per Case Prospective Payment for Episodes of Hospital Care)

Project No.:	500-92-0020DO07
Period:	June 1993–June 1995
Funding:	$ 644,052
Award:	Delivery Order in Master Contract
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Teresa L. DeCaro Division of Payment and Economic Studies

Description: This study seeks to produce alternative prospective per case payment models for episodes of hospitalization that expand the current boundaries of payment consolidation under Medicare's fee-for-service reimbursement policies. Specific tasks include: defining episodes of care that are anchored to acute hospitalizations; analyzing service bundles that make up the episodes; identifying and analyzing design, administrative, legal, transition, and other issues important to the potential implementation of selected models; calculating payment weights; conducting "spending neutral" impact simulations of selected payment models; and exploring alternative uses of payment weights (e.g., ratesetting by other payers, determining global budgets, and measuring financial risk). A technical advisory panel (TAP) made up of experts in research, medicine, group practice and hospital administration, claims data collection and management, and contract negotiations are providing guidance and feedback to the awardee throughout the life of the project.

Status: Payment models being explored include both physician services only and a combined payment for facility (Medicare Part A) and physician (Part B) services. Using the Health Care Financing Administration's (HCFA) 1992 5-month, 100-percent hospital admission and episode data base, descriptive analyses on various bundle definitions are being completed. Variation in utilization is case-mix-adjusted using HCFA's refined diagnosis-related groups (DRG). Additionally, a draft document of the payment system is in production. Final design parameters will be based on the descriptive analyses, feedback from the TAP panel, case studies of selected hospitals and claims processing entities, and in consultation with a legal expert and a panel of physicians.

92-004 Reasonable Charge Impact Studies

Project No.:	17-C-90159/3
Period:	November 1991–December 1993
Funding:	$ 347,818
Award:	Cooperative Agreement
Principal Investigator:	George Kowalczyk
Awardee:	HK Research Corporation 477 White Plains Court Severna Park, MD 21146
HCFA Project Officer:	Benson L. Dutton Division of Payment and Economic Studies

Description: This project was a continuation of work on physician payment that was performed under a previous cooperative agreement, No. 17-C-99229/3, Analysis of Medicare Customary Charge Distributions. Its purpose was to collect the current reasonable charge pricing, volume (claims), and provider characteristics data files; to standardize these data to improve their comparability between carriers; and to perform descriptive analyses that update and enhance the descriptive studies performed under the earlier project. HK Research Corporation used claims data from carriers in Alabama, Arizona, District of Columbia, Indiana, Maryland, Massachusetts, Oklahoma, Oregon, and Pennsylvania. These data included customary charge, prevailing charge, and other reasonable charge pricing data for the years 1987–93. HK Research Corporation has completed tasks contributing to the development of data for the 1993 Annual Report to Congress on access to care, as well as the file creation and analysis of data addressing the impact of changes resulting from reclassification of physician specialties.

Status: This project has been completed. The final report, "Reasonable Charge Impact Studies," was submitted to the Office of Research and Demonstrations in January 1994 and is available from the National Technical Information Service, accession number PB94-181724.

94-009 Reliability and Adequacy of Coded Diagnoses and Procedures for Services Provided in Physician Office Settings

Project No.:	500-94-0003
Period:	February 1994–September 1994
Funding:	$ 29,697
Award:	Contract (8A)
Principal Investigator:	Robert E. Burke, Ph.D.
Awardee:	Allied Technology Group, Inc. 1803 Research Boulevard, Suite 601 Rockville, MD 20850
HCFA Project Officer:	William J. Sobaski Division of Payment and Economic Studies

Description: This project was to develop a concept paper on determining the reliability and adequacy of coded diagnoses and procedures for services provided in physician office settings. Prior to developing the concept paper, the awardee performed a literature review and met with a number of recognized coding experts and with practicing physicians to gain broad perspectives on these data reliability considerations. The concept paper describes several alternative study approaches that might be undertaken to quantify the extent, causes, and consequences of unreliability in the coded data that the Health Care Financing Administration obtains for physician office procedures and the diagnoses to which they relate. The awardee also is to propose a small scale pilot study that might be undertaken to assess the feasibility of performing the study of diagnosis and procedure coding reliability that the awardee believes would be most appropriate.

Status: The awardee has submitted a literature review report and periodic progress reports indicating that all preparatory steps for preparing the concept paper and pilot study specifications have been performed. The final report, "Determining Reliability and Adequacy of Coded Diagnoses and Procedures for Services Provided in Physician Office Setting," is available from the National Technical Information Service, accession number PB95-154761.

92-055 Research Plan for Hospital Payment Policy Interactions

Project No.:	500-92-0024DO02
Period:	September 1992–September 1994
Funding:	$ 166,687
Award:	Delivery Order in Master Contract
Principal Investigator:	Margaret Sulvetta, Ph.D.
Awardee:	The Urban Institute (See page 215)
HCFA Project Officer:	Philip G. Cotterill, Ph.D. Division of Payment and Economics Studies
Mandate:	Social Security Amendments of 1983 (Public Law 98-21)

Description: This project is developing a research plan to study interactions in Medicare hospital payment policy. It is possible that "policy" interactions among Medicare payment methods for different services and settings may create undesirable incentives. Medicare policy is typically segmented by service, and elements that are common across payment policies (such as adjustment for labor costs) may be applied differently across services or settings. "Behavioral" interactions also may exist. That is, changes in payment policy for one service or setting can have impacts on another service or setting. This project has five parts: health systems overview, in which a conceptual approach to researching hospital policy interaction issues is developed; research strategy, where policy and behavioral interactions are put into an analytical framework to address research questions more precisely; literature review; research agenda; and data base planning.

Status: Two products, the literature review and a review of Medicare payment policies across settings and services, have been completed. An agenda for future research is forthcoming.

94-003 Sampling Plan for Part B Physician Sample and Statistical Tests on Sample

Project No.:	HCFA-94-0162
Period:	December 1993–February 1994
Funding:	$ 4,000
Award:	Contract
Principal Investigator:	James C. Beebe
Awardee:	James C. Beebe 1345 Tydings Road Annapolis, MD 21401
HCFA Project Officer:	Ann Meadow, Sc.D. Division of Payment and Economic Studies

Description: In 1992 the Health Care Financing Administration (HCFA) designed a physician sample to replace the Part B Medicare Annual Data Provider File, which for several years supplied Medicare claims data to

support numerous studies of physician payment and other issues. Based on the terminal digits of the Unique Physician Identification Number (UPIN), the new Part B physician sample is self-weighing and intended to be representative of the physicians treating Medicare beneficiaries. The data base comprises detailed line item information from all available claims of the sample physicians. Initial experience with the sample indicated that target State sample sizes generally were not achieved. The main purpose of this project was to evaluate the initial sampling plan in terms of the original sample design goals, including representativeness and statistical power, and to develop a revised sampling plan.

Status: The final report, "Evaluation of the Five percent Part B Physician Sampling Plan and Recommended Revised Specifications for the 1993 Sample," is available from the HCFA Project Officer. The evaluation was based on the 1991 and 1992 samples from 18 States. It forecasts a shortfall of about one-third in the number of physicians in the 1993 sample, under a continuation of the original sampling plan. It also found that the original estimate of variability in the data was probably too high. However, under conservative assumptions about the variability, the revised design called for the addition of terminal digit pairs in some States to meet the design goal of a 7.5-percent relative precision. On sample representativeness, the evaluation found that, in 10 of the 18 States, there was no statistically significant difference between the specialty distribution in the sample and HCFA's UPIN Registry, which was used as the sampling frame. Frequently, pediatricians and other specialties unlikely to bill Medicare were important contributors to the chi-square statistics assessing representativeness.

91-016 Staff-Assisted Home Dialysis Demonstration

Project No.:	500-87-0030TO09
Period:	June 1991–December 1995
Funding:	$ 914,203
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Andrea Hassol
Awardee:	Abt Associates Inc. (See page 216)
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: This demonstration is to test whether providing Medicare-paid home hemodialysis assistants for end stage renal disease (ESRD) patients meeting stringent eligibility criteria (e.g., bed- or wheelchair-bound) is cost effective, in that it reduces Medicare-covered ambulance costs for transporting patients to maintenance dialysis in facilities or reduces hospital admissions attributed to transportation-related problems. The legislation limits the experimental benefit to a maximum of 800 patients and stipulates a detailed ratesetting formula.

Status: Letters of solicitation were sent to all dialysis facilities in January 1992, and outreach efforts were undertaken in 1992 and 1993. However, as of the close of the enrollment period, April 1994, less than 100 patients had been enrolled in the demonstration. Although about half of the enrollees had been assigned to the experimental group, less than 40 patients actually received the experimental benefit, and most received it for less than 6 months. Patients were withdrawn from home hemodialysis when they became too ill, were admitted to a nursing home, or died. This demonstration had an annual mortality rate in excess of 50 percent. An interim report was submitted to Congress in January 1993. The final Report to Congress is due December 31, 1995. Since the demonstration did not have a sufficient number of patients for meaningful statistical analysis, a series of related research studies has been undertaken: comparing and contrasting demonstration enrollees with ambulance-using ESRD patients not enrolled in the demonstration; identifying detailed characteristics of ESRD ambulance users; assessing reasons for and alternatives to ambulance transport to dialysis; comparing and contrasting ESRD nursing home residents with other ESRD patients; and analyzing the components of cost for high-cost ESRD patients.

94-004 State-Specific Sampling Plans for 1993 Part B Physician Sample

Project No.:	HCFA-94-0824
Period:	June 1994–September 1994
Funding:	$ 2,000
Award:	Contract
Principal Investigator:	James C. Beebe
Awardee:	James C. Beebe 1345 Tydings Road Annapolis, MD 21401
HCFA Project Officer:	Ann Meadow, Sc.D. Division of Payment and Economic Studies

Description: In 1992 the Health Care Financing Administration (HCFA) designed a physician sample to replace the Part B Medicare Annual Data Provider File, which for several years supplied Medicare claims data to support numerous studies of physician payment and other issues. Based on the terminal digits of the Unique Physician Identification Number (UPIN), the new sample is self-weighing and intended to be representative of the physicians treating Medicare beneficiaries. The data base comprises detailed line item information from all available claims of the sampled physicians. The purpose of this project was to revisit the 1992 design recommendations to develop a more efficient Part B physician sample. A previous evaluation of the sample design (see identification number 94-003, Project No. HCFA-94-0162) had suggested that variability in the physician data was overestimated, leading to sample sizes that could exceed precision requirements. Subsequently, new summary data on 100 percent of physician billings from the National Claims History (NCH) yielded State variability estimates useful in respecifying the sample. The summary data also permitted better enumeration of physicians actively billing Medicare than did the original sampling frame (the national UPIN Registry).

Status: This project has been completed. Based on 1992 variability and enumeration data obtained from the NCH summaries, the awardee has submitted a revised list of terminal digit pairs for drawing the 1993 Part B physician sample. The target national sample size for 1992 is 22,537 physicians. The earlier 1991 and 1992 samples will be redrawn under the new specifications. The final report, "Part B Physician Sample Redesign," describes and justifies the new sampling methodology and presents methods for combining the State data in statistical tests. The report will be available from the National Technical Information Service.

90-057 Statistical Properties of Physician Practice Cost Surveys

Project No.:	99-C-99168/3
Period:	September 1990–July 1993
Funding:	$ 67,718
Award:	Cooperative Agreement
Principal Investigator:	Curt Mueller, Ph.D.
Awardee:	The People-to-People Health Foundation, Inc. (See page 210)
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Division of Payment and Economic Studies

Description: The purpose of the project was twofold: to perform a systematic review of the 1988 Physicians' Practice Cost and Income Survey (PPCIS) public use data tape and the accompanying public use code book; and to analyze the statistical properties of selected national physician surveys. The first analysis assessed the accuracy and usability of these data for analysis. The second analysis assessed specific characteristics of the 1988 PPCIS: characteristics associated with whether a physician or nonphysician respondent provided practice cost data for the survey; and the incremental costs associated with services that are provided in the office versus other practice settings.

Status: This project has been completed. The final report, "Statistical Properties of Physician Surveys—Proxy Response and Survey Error: Additional Evidence from the 1988 Physicians' Practice Costs and Income Survey," is available from the National Technical Information Service, accession number PB94-106275.

94-132 Study of Resource-Based Outpatient Facility Costs

Project No.:	17-C-90379/3
Period:	September 1994–September 1995
Funding:	$ 140,000
Award:	Cooperative Agreement
Principal Investigator:	Henry Miller, Ph.D.
Awardee:	Center for Health Policy Studies 9700 Patuxent Woods Drive Columbia, MD 21046
HCFA Project Officer:	Michael Henesch Division of Hospital Experimentation

Description: This study will expand upon earlier work performed by the awardee in the Measurement of Outpatient Facility Resource Costs study to measure resource use and costs for a variety of outpatient procedures as categorized in the ambulatory patient groups classification system. A research design will be developed by the awardee that will include an examination of the causes of differences in resource costs between various outpatient settings. In addition, the awardee will develop resource costs for immunization procedures to meet congressional expectations in implementing the Vaccine for Children Program. Although some immunization procedures were measured in the earlier study, these efforts were limited in terms of specific immunizations studied and the sample size. In this study, resource costs will be developed at a sufficient level of detail to be certain that the nature of resources used and the costs of each resource are identified. The

study is expected to utilize the resource profile data base from the earlier study except for the immunization profiles. For the immunization cost task, a sample of clinics and physician offices will be selected for data collection of standardized immunization profiles for each site. Data for a sample of sites will be collected through visits for detailed onsite data collection. A technical advisory panel will be convened to review the findings.

Status: This project is in the early developmental stage.

91-080 Teaching Physicians and the Medicare Program

Project No.:	17-C-90015/1
Period:	September 1991–October 1995
Funding:	$ 463,765
Award:	Cooperative Agreement
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	William Buczko, Ph.D. Division of Payment and Economic Studies

Description: Relatively little is known about teaching physicians, their practice organization, their billing patterns, and their cost to the Medicare program. This study will examine practice plans in 10 hospitals to determine how practice in teaching hospitals is organized. Also, Part A and Part B claims will be merged with Medicare Cost Report data to determine the total cost of physicians' services in teaching hospitals as well as the extent of "double payment" by physicians. These data also will be used to evaluate the impact of the Medicare fee schedule on teaching physicians and related effects on volume of services performed.

Status: Site visits to case study hospitals have been completed and described in reports for each site. A summary report of these findings, "Teaching Physicians and the Medicare Program: A Case Study," is available from the awardee. Analyses of Hospital Cost Report Information System (HCRIS PPS-7) cost report data and interns and residents data have been completed and presented in a draft report. Analysis of Part A and Part B claims in the merged Part A/Part B data base has been presented in a draft report. Analysis of 1993 Part A data began in September 1994. Part B claims for 1993 will be drawn in late 1994. A merged Part A/Part B file will be created and analysis of 1993 Part A/Part B data will begin in January 1995.

93-044 Unique Physician Identification Number Validation Studies (Formerly, Uniform Physician Identifier Number Validation Studies)

Project No.:	500-92-0020DO05
Period:	June 1993–July 1994
Funding:	$ 151,862
Award:	Delivery Order in Master Contract
Principal Investigator:	Killard W. Adamache, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Ann Meadow, Sc.D. Division of Payment and Economic Studies

Description: This project researched methods for improving the reliability and validity of the Unique Physician Identification Number (UPIN) and related data. Under a congressional mandate, a UPIN is assigned to each Medicare physician. UPIN system records contain basic professional characteristics data on each assignee. The UPIN system offers a tool for improving administrative functions such as developing new payment policies, monitoring impacts of policy changes, and uncovering fraud and abuse.

Status: This project has been completed. The awardee conducted site visits at six Medicare carriers and three health maintenance organizations (HMO); analyzed the characteristics and limitations of UPIN data elements nationally and for each carrier; developed computer programs and flow charts to describe the desired analytic and corrective procedures; designed and produced a series of record-specific reports to aid carriers in retrospectively correcting UPIN records; and produced several estimates addressing additional issues of physician enumeration. Analysis of the integrity of UPIN data elements covered all 1.68 million active practice setting records (representing 657,000 physicians) in the UPIN system as of July 1993. It revealed that for each of four key data elements—date of birth, professional school code, graduation year, and State license number—the proportion of records with missing, erroneous, dubious, or unknown values was 10 to 15 percent. Integrity measures for individual variables were poorest for practice setting records submitted in 1989, the first year of UPIN Registry operations. There was considerable variation in data element integrity by carrier. The prevalence of conflicting data within an individual practice setting record generally did not exceed 5 percent for any given comparison (e.g., conflict between physician's specialty and credential). Among the 271,635 physicians with multiple practice setting records

containing feasible values in the date of birth field, inconsistent information affected 4 percent. Similarly, with regard to graduation year and professional school code, about 5 percent of the physicians with multiple, feasible values for each data element had an inconsistency. Findings from the various enumeration analyses included: Some 2,200 or more physicians have been assigned more than one UPIN. There are no apparent instances in which a UPIN has been inadvertently assigned to a medical group or corporation. The number of HMO physicians who treat Medicare beneficiaries but do not have a UPIN is estimated to be only 3,069 nationally, or 20 percent of HMO Medicare physicians. Finally, enumeration of the physicians electing to join the Medicare Participating Physician Program, based on Registry data, departs markedly from results obtained using the National Claims History. Four of the five deliverables produced under this contract are available from National Technical Information Service:

- "Unique Physician Number (UPIN) Validation Studies: Carrier Analysis," PB95-138806, describes the characteristics and limitations of UPIN data elements nationally and by carrier.
- "Unique Physician Number (UPIN) Validation Studies: Carrier Edits," PB95-138780, provides computer programs and flow charts describing analytic and corrective procedures for carriers.
- "Unique Physician Number (UPIN) Validation Studies: Researcher Edits," PB95-138772, provides computer programs and flow charts describing analytic and corrective procedures for researchers.
- "Unique Physician Number (UPIN) Validation Studies: Documentation for the UPIN Integrity and Multiple UPIN Files," PB95-137881, describes the use of computer programs that produce a series of record-specific reports to assist carriers in retrospectively correcting UPIN records.

90-034 Volume-Adjusted Payment for Clinical Laboratory Services

Project No.:	99-C-99169/5
Period:	August 1990–April 1993
Funding:	$ 99,457
Award:	Cooperative Agreement
Principal Investigator:	Bruce Kinosian, M.D.
Awardee:	The University of Minnesota
	(See page 217)
HCFA Project Officer:	Victor G. McVicker Division of Hospital Experimentation

Description: The University of Pennsylvania is completing a project designed to examine the impact of practice setting and technology on the cost of producing laboratory services. Researchers at the University have focused on the 35 clinical chemistry, hematology, and toxicology kits most commonly paid by the Medicare program in 1986 and 1987. This project will extend the current work to examine the profitability of performing these tests as a function of testing volume. Researchers will analyze several data sources and will validate the model with actual laboratories' data for the appropriate volume. Findings will be used to examine alternative payment methods.

Status: The University of Pennsylvania has submitted the first two chapters of the final report. The remainder of the final report is expected in November 1994.

Access and Quality of Care

92-014 Access to Care in the Medicaid Program

Project No.:	18-C-90134/3
Period:	February 1992–October 1994
Funding:	$ 253,118
Award:	Cooperative Agreement
Principal Investigator:	Jack Hadley, Ph.D.
Awardee:	Georgetown University Center for Health Policy Studies 2233 Wisconsin Avenue, NW., Suite 525 Washington, DC 20007
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Program Studies

Description: This study addressed two research questions: Did Medicaid-enrolled and uninsured women and children have the same access to care as did the privately insured? and How did variations in Medicaid policies and potential access barriers affect the use of services?

Status: Georgetown University is preparing the final report. Differences in access to care were inferred from analyses of four sets of access indicators that were constructed from hospital discharge data: admissions for ambulatory care sensitive conditions (i.e., preventable or avoidable hospitalizations); admissions for diagnoses and use of procedures, given a diagnosis for which medical necessity is relatively clear-cut; admissions for diagnoses and use of procedures for which medical necessity is less clear or for which there is greater discretion from the physician's perspective; and outcomes of care. Data between 1986 and 1990 from up to 15 States were pooled and used in the analyses.

91-039 Access to Kidney Transplant Waiting List

Project No.:	99-C-98489/9
Period:	August 1991–January 1993
Funding:	$ 135,884
Award:	Cooperative Agreement
Principal Investigator:	Joel D. Kallich, Ph.D.
Awardee:	The RAND Corporation
	(See page 211)
HCFA Project Officer:	Paul W. Eggers, Ph.D. Division of Beneficiary Studies

Description: RAND assessed the rate of referral to the transplant waiting list among end stage renal disease (ESRD) beneficiaries. This was accomplished by linking waiting list data from the United Network for Organ Sharing (UNOS) with the Health Care Financing Administration's ESRD Program Management and Medical Information System data. Racial differences in access to care also were assessed by measuring the length of time from referral to the waiting list until transplantation.

Status: From July 1, 1988, to November 1, 1991, there were 36,776 persons placed on the UNOS kidney transplant waiting list. Of this number, 51.8 percent received a transplant, 12.7 percent were removed from the list (died, moved, refused, medical, or unknown reason), and 35.5 percent remained on the waiting list. Analyses confirm results from other studies about racial differences in waiting times to transplant. White persons waited an average of 10.7 months until transplant while black persons waited an average of 16.5 months. Results from this study are included in "Access to Cadaveric Kidney Transplantation" (RAND Publication No. MR-202-HCFA) by Joel D. Kallich, John L. Adams, Phoebe Lindsey Barton, and Karen L. Spritzer. Copies may be ordered from RAND, 1700 Main Street, Post Office Box 2138, Santa Monica, California 90407-2138.

92-095 Access to Medicare Physician Services

Project No.:	17-C-90044/3
Period:	March 1992–February 1995
Funding:	$ 710,421
Award:	Cooperative Agreement
Principal Investigator:	Stephen Zuckerman, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Paul W. Eggers, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: This cooperative agreement comprises three tasks related to Medicare beneficiary access to physician services. Task 1 involves measuring trends in the volume and intensity of Medicare physician services. Task 2 involves the analysis of the relationship between pricing policies and access to Medicare physician services. Task 3 uses the 1992 Medicare Current Beneficiary Survey to study beneficiary access to physician services.

Status: Initial analyses under Task 1, i.e., tracking changes in the volume and intensity of physician services between 1985 and 1990 using relative value units, have been completed. Estimates of changes using this system are lower than earlier estimates by the Urban Institute using a price index approach. This suggests that the price index approach may have underestimated price growth, thus overstating volume and intensity growth. Sample design, including selection of physician specialties has been completed for Task 2. Task 3 depends on access to the Medicare Current Beneficiary Survey as an analytical data base. Most of the work on this task will take place in the final year of the project.

89-014 Analysis of Medicare Expenditures for Ambulance Services

Project No.:	99-C-99168/3
Period:	August 1989–July 1991
Funding:	$ 173,711
Award:	Cooperative Agreement
Principal Investigator:	Penny E. Mohr
Awardee:	The People-to-People Health Foundation, Inc.
	(See page 210)
HCFA Project Officer:	Herbert A. Silverman, Ph.D. Division of Program Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: This project was funded to produce data for a Report to Congress as mandated by Public Law 101-239 on expenditures for ambulance services under Medicare. Patterns of use, access, and spending for ambulance services are examined for urban and rural areas by type of ownership and by level of service (i.e., "basic or advanced life support"). Estimates of average and marginal costs are made for services in urban and rural areas by type of service and level of service.

Status: This report was submitted to Congress in February 1994. The principal findings (based on 1987 data) were:

- Rate of ambulance use was higher among Medicare beneficiaries in urban areas (65 users per 1,000 beneficiaries) than it was in rural areas (57 users per 1,000 beneficiaries).
- Urban residents make more frequent use of ambulance services (110 runs per 1,000 beneficiaries) than do rural residents (89 runs per 1,000 beneficiaries). Average allowed charge per run was higher in urban areas ($134) than it was in rural areas ($110).
- Add-ons to the base ambulance rate increased average allowed charges per run by 42 percent for basic life support (BLS) vehicles and by 74 percent for advanced life support (ALS) vehicles.
- Medicare-allowed charges were higher, on average, than was the average cost of ambulance services for government and volunteer ambulance providers for both BLS and ALS services (based on a 4-State survey).
- Medicare-allowed charges were roughly comparable to the average cost of private ambulance companies in providing scheduled runs—in the 4-State survey, scheduled runs represented 55 percent of the runs provided by private firms.
- Average costs for emergency (i.e., unscheduled) runs (for both BLS and ALS) by private providers were substantially higher than were allowed charges.
- Level of transportation provided, in many instances, was higher than required by the patient's medical needs (i.e., ALS vehicles were used when BLS services would have sufficed).

No recommendations were made for legislative changes affecting Medicare's ambulance benefit. Several proposals were made to improve administrative monitoring of ambulance services.

93-065 Assessment of the Impact of Medicaid Drug Rebate Policy on Expenditures, Utilization, and Access
(Formerly, Impact of the Medicaid Drug Rebate Policy on Expenditures, Utilization, and Access)

Project No.:	500-92-0022DO03
Period:	September 1993–June 1994
Funding:	$ 339,848
Award:	Delivery Order in Master Contract
Principal Investigator:	Jon Christianson, Ph.D.
Awardee:	The University of Minnesota (See page 214)
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Beneficiary Studies

Description: The purpose of this study is to assess the impact of the Medicaid drug rebate program on expenditures, utilization, and access to medications for Medicaid recipients. Stephen Schondelmeyer is the lead researcher for this project. The study will use a decomposition analysis to determine the change in total drug expenditures before and after implementation of the Medicaid drug rebate program. The role of covered population changes, intensity (utilization rate) changes, changes in efficiency (drug product prices), changes in dispensing fees and changes in rebates, and administrative costs will be evaluated. The impact on recipient access will be assessed by constructing a person-level file of prescription drug claims both pre- and post-Omnibus Budget Reconciliation Act of 1990 (legislation that mandated the drug rebate program).

Status: The final report is expected to be completed by October 31, 1994.

91-038 Beneficiary Access to and Utilization of Physician Services: Developing Baseline and Followup Measures for Assessing Physician Payment Reform

Project No.:	99-C-99168/3
Period:	August 1991–January 1993
Funding:	$ 84,112
Award:	Cooperative Agreement
Principal Investigator:	Karen Stewart
Awardee:	The People-to-People Health Foundation, Inc. (See page 210)
HCFA Project Officer:	Lawrence E. Kucken Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: For this project, Project HOPE developed an empirical framework for monitoring physician service access and utilization following the implementation of physician payment reform. The study focused on the development of baseline measures of physician supply (physician-to-population ratios) prior to the implementation of Medicare's physician fee schedule for the period 1984-90. Ratio measures were developed from the Health Care Financing Administration's (HCFA) Medicare denominator file and the Health Resources and Services Administration's area resource file.

Status: The final report has been accepted by HCFA and is being sent to the National Technical Information Service. The report indicates that the Northeast and

West regions of the country display much higher concentrations of physicians than does the rest of the United States. Similarly, the report confirms higher physician concentrations in metropolitan areas compared to those in nonmetropolitan areas.

92-096 **Build and Test a Viable Automatic Pressure Compensating Mechanism for Low-Cost, High-Quality Intravenous Flow Control**

Project No.:	97-P-08022/1
Period:	September 1992–September 1993
Funding:	$ 100,904
Award:	Grant
Principal Investigator:	Charles Khuen
Awardee:	IV Systems, Inc. 131 Forest Street Winchester, MA 01890
HCFA Project Officer:	Carl S. Hackerman Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project will build a line of low-cost, accurate, gravity-driven, intravenous flow control products based on a patented approach to flow control.

Status: This project has completed Phase II (build and test). A final report has been received. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

93-005 **California Welfare Reform: Assistance Payments Demonstration Project** (Formerly, California Assistance Payment Demonstration)

Project No.:	11-W-00018/9
Period:	December 1992–November 1997
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Eloise Anderson
Awardee:	California Department of Social Services 744 P Street Sacramento, CA 95814
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration originally had waivers from the Administration for Children and Families (ACF) that removed the time limitation on the disregard of earnings of recipients of Aid to Families with Dependent Children (AFDC) and removed the limitation on hours of work in two-parent families in California. Subsequent ACF waivers were added, permitting the State to give teenage parents bonuses/penalties in the AFDC grant payment for grade averages above/below certain levels; increasing resource limitations and disregarding restricted savings accounts; implementing certain changes in the Job Opportunities and Basic Skills program required under Federal law; and allowing recipients with earned income to choose child care assistance in lieu of a cash grant. In conjunction with this demonstration, the State decreased the welfare payment, which did not require an ACF waiver. The Health Care Financing Administration (HCFA) granted a "maintenance of effort" waiver, permitting the approval of State Medicaid plans, even though the AFDC payment level was below the level in effect on May 1, 1988. HCFA also authorized the State to maintain the eligibility level of its Medically Needy program, making the medically needy eligibility level more than 133 1/3 percent of the lowered AFDC payment level.

Status: The reduction in AFDC benefits was contested. In July 1994, the court remanded the case to the Secretary of the Department of Health and Human Services for additional consideration.

91-058 **Center Billings for Ancillary Dialysis Services**

Project No.:	99-C-98489/9
Period:	August 1991–July 1993
Funding:	$ 120,000
Award:	Cooperative Agreement
Principal Investigator:	Joel D. Kallich, Ph.D.
Awardee:	The RAND Corporation (See page 211)
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies

Description: Medicare pays a fixed (composite rate) for each dialysis session including supplies, drugs, and tests. There are ancillary services that could be considered as part of the dialysis session but may be billed separately at times. This study has compiled a list of these ancillary services and has examined the current quantity and costs

of supplies, drugs, laboratory tests, and radiology services provided to dialysis patients supplementary to those covered in the composite rate.

Status: A draft final report has been received.

94-077 Changes in Population Characteristics and Medicaid Utilization/Expenditures among Children and Adolescent Supplemental Security Income Recipients

Project No.:	18-C-90455/1
Period:	September 1994–September 1996
Funding:	$ 581,035
Award:	Cooperative Agreement
Principal Investigator:	James Perrin, M.D.
Awardee:	Massachusetts General Hospital Children's Service Fruit Street, WACC 715 Boston, MA 02114
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Program Studies

Description: The Supplemental Security Income (SSI) program for children and adolescents has expanded in the past 5 years as a result of new Social Security Administration (SSA) guidelines for determining disability caused by mental impairments, new guidelines for determining childhood disability in general, and major outreach efforts by SSA to identify children with disabilities. The project has four main objectives:

- Determine the current clinical characteristics of child and adolescent SSI recipients and the changes in these characteristics during the period of program expansion that began in the late 1980s.
- Determine patterns of Medicaid utilization and expenditures among important clinical subgroups and examine changes in these patterns during the period of program expansion.
- Examine the utilization trajectories and clinical characteristics of certain SSI recipient groups over time, including recipients with high-cost physical conditions such as cystic fibrosis, congenital heart disease, and spina bifida, and high-prevalence, low-cost conditions such as attention deficit, hyperactivity disorder, and learning disabilities.
- Determine the degree to which new recipients reflect shifting among Medicaid eligibility categories and the coverage and use of other insurance after getting SSI.

Status: This project is in the early developmental stage.

94-071 Colorado Welfare Reform: Personal Responsibility and Employment Program

Project No.:	11-W-00009/8
Period:	November 1993–October 1997
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Barbara McDonnell
Awardee:	Colorado Department of Human Services 1575 Sherman Street Denver, CO 80203-1714
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Health Care Financing Administration, the Administration for Children and Families, and the Department of Agriculture (Food Stamps) to:

- Consolidate the Aid to Families with Dependent Children (AFDC) grant, Food Stamps, and child care benefits into a single cash payment.
- Impose AFDC financial sanctions on families if children under 2 years of age are not immunized or employable adults are noncooperative after 2 years.
- Increase disregards of earnings and assets and provide financial incentives to participants who graduate from high school or who obtain a high school equivalency.
- Allow cases that have been on AFDC for less than 3 of the previous 6 months to receive the Medicaid transition benefit, if they lose AFDC eligibility because of earnings and eliminate quarterly income reporting during the transition period, reporting only income increases.

Status: This project is in the early implementation phase.

92-058 Comparative Study of the Use of Early and Periodic Screening, Detection, and Treatment and Other Preventive and Curative Health Care Services by Children Enrolled in Medicaid

Project No.:	500-92-0066
Period:	September 1992–August 1995
Funding:	$ 1,262,400
Award:	Contract
Principal Investigator:	Norma Gavin, Ph.D.
Awardee:	SysteMetrics, Division of MedStat, Inc. 777 East Eisenhower Parkway, Suite 500 Ann Arbor, MI 48108
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Program Studies

Description: The contract comprises a series of research projects designed to:

- Study the effect of the changes in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program introduced by the Omnibus Budget Reconciliation Act of 1989 on the process of providing health services to children and on the appropriateness of expenditures for the services provided in Tennessee, Georgia, Michigan, and California.
- Compare Medicaid-enrolled children in four EPSDT programs with other Medicaid-enrolled children in the four States who are not receiving EPSDT services, regarding enrollment patterns, service utilization, and expenditures, with a particular emphasis on preventive health services.
- Compare Medicaid-enrolled children with non-Medicaid-enrolled children, insured and uninsured, on the use of and expenditures for preventive services and other health care services, using national survey data.

Status: Site visits have been completed for all four States. A revised report on the four site visits is being prepared. The 1989 analyses have been completed, and the 1992 data files have been constructed. Reports submitted include:

- Adams, E.K., and Graver, L.: Analysis of Medicaid Provider Supply Overall and for Preventive Care Services for Children, 1989. June 1994.
- Gavin, N.: Review and Synthesis of the Literature on the Implementation and Effectiveness of Recent Legislative Initiatives Relating to Medicaid and EPSDT Coverage for Children. December 15, 1992.
- Gavin, N., and Bencio, D.S.: Comparison of Access to Care Among Medicaid and Other Groups of Children: 1982 and 1988 National Health Interview Surveys. November 23, 1993.
- Herz, L., Gavin, N., Ellwood, M., and Sredl, K.: The Use of EPSDT and Other Health Care Services by Medicaid Children, 1989. May 3, 1994.

92-015 Comparison of the Accuracy of Several Screening Systems for Hospital Quality Assessment

Project No.:	17-C-90099/3
Period:	February 1992–September 1994
Funding:	$ 224,500
Award:	Cooperative Agreement
Principal Investigator:	Haya R. Rubin, M.D.
Awardee:	The Johns Hopkins University School of Medicine 720 Rutland Avenue Baltimore, MD 21205
HCFA Project Officer:	Harry L. Savitt, Ph.D. Division of Beneficiary Studies

Description: The main objectives of this study are to measure the sensitivity, specificity, predictive values, and reliability of three methods of screening medical records for problems in quality of care—the Uniform Clinical Data Set (UCDS), the Health Care Financing Administration's Generic Screens, and the Harvard Medical Practice Study Screening Criteria. The reference standard is a judgment of the quality of the process of care by cardiologists who conduct a structured review of the medical record. A sample of charts will be reviewed among patients admitted to Johns Hopkins Hospital, Baltimore, Maryland, between July 1, 1989, and June 30, 1991, with a principal diagnosis of myocardial infarction or ischemic heart disease with a revascularization procedure (percutaneous transluminal cardiac angioplasty and coronary artery bypass graft) to determine the set of screens with the highest accuracy and to indicate modifications that can improve the performance of individual screens.

Status: A sample of 440 medical records were reviewed from patients admitted to Johns Hopkins Hospital between July 1, 1989, and June 30, 1991, for treatment of ischemic heart disease, myocardial infarction, with or without a revascularization procedure (angioplasty and coronary bypass graft). The charts were abstracted by nurses and reviewed by cardiologists whose judgment of the quality of care is taken as a reference. A subsample was reviewed twice to assess the interrater agreement. The nurses were trained in the use of UCDS software for chart review. Physicians also were trained to perform a structured review using forms and guidelines developed to ensure that the same core of elements of interest for quality assessment are taken into consideration. All of the cases were reviewed and preliminary data analysis was conducted. In addition to sensitivity, specificity, and predictive values of the screening systems, the set of screens with the highest accuracy will be determined. Recommendations that can make individual screens more accurate, based on the results, will be made.

93-013 Computerized Drug Regimen Review System

Project No.:	97-P-08053/9
Period:	February 1993–January 1993
Funding:	$ 34,960
Award:	Grant

Principal Investigator: Mira Zeffren
Awardee: Patient Care Pharmacy, Inc.
6300 Arizona Circle
Los Angeles, CA 90045
HCFA Project Officer: Leslie A. Mangels
Office of Operations Support

Mandate: Small Business Innovation Development Act of 1982
(Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The purpose of this project was to develop and distribute a computerized drug regimen review system designed to aid pharmacists in providing services to skilled nursing facilities.

Status: Phase I (development) was completed. A final report has been received. The awardee did not seek Phase II (product development) support. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

94-069 Connecticut Welfare Reform: A Fair Chance

Project No.: 11-W-00022/1
Period: September 1994–August 2001
Funding: Waiver only
Award: Waiver-only Project
Principal Investigator: Patricia Giardi
Awardee: Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
HCFA Project Officer: Bonnie M. Edington
Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Health Care Financing Administration, the Administration for Children and Families, and the Department of Agriculture (Food Stamps) to:

- Allow children to receive assistance even if living with both parents.
- Require adults to work at least 10 hours per week in the Community Work Experience Program, for pay, if unemployed.
- Increase income disregards, resource and asset limits, and the child support pass-through.
- Coordinate Aid to Families with Dependent Children (AFDC) and Food Stamp sanctions for quitting employment.
- Extend transitional child care benefits if income is below 75 percent of the State median income.
- Provide case management for 1 year after the loss of AFDC eligibility.
- Extend the Medicaid transition benefit to 2 years, regardless of income, but require recipients to report on the availability of employer health insurance.

Status: This project is in the early implementation phase.

93-027 Cost Containment of Intravenous Drug Therapy in Home Care

Project No.: 97-P-08020/9
Period: February 1993–January 1994
Funding: $ 33,720
Award: Grant
Principal Investigator: Eric W. Brown
Awardee: TechnoView, Inc.
98 Baycrest Court
Newport Beach, CA 92660-8922
HCFA Project Officer: Joanna K. Bandzwolek
Office of Operations Support

Mandate: Small Business Innovation Development Act of 1982
(Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project developed the methodology and built and tested an intravenous drug delivery monitor for use by researchers monitoring patients being treated for serious diseases at home via home health care service providers and family members when nurses are not present.

Status: Phase I (development) was completed. A final report has been received. However, Phase II (testing and data gathering) was not funded. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-045 Cost-Containment Measures for Physician and Other Services

Project No.:	500-89-0052
Period:	August 1992–November 1993
Funding:	$ 71,957
Award:	Contract
Principal Investigator:	Suzanne Felt
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW., Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	Herbert A. Silverman, Ph.D. Division of Program Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The awardee conducted a survey of all State Medicaid agencies concerning their utilization management activities, including ambulatory surgery, preadmission testing, same-day surgery, primary care or other case management, preadmission certification, lock-in, rebundling, and second surgical opinion. The objective of the survey was to determine which States have which types of programs; the characteristics of the programs, including target populations, subject procedures, and payment issues; and the evidence and opinions States have as to the effects of each of the programs on access to necessary care, quality of care, and costs of care.

Status: Mathematica has submitted a report of its survey findings and a review of the literature. A Report to Congress has been drafted and is undergoing administrative review at the Health Care Financing Administration. Release of the Report to Congress is anticipated to be in early 1995.

90-055 Cost and Outcomes from Different End Stage Renal Disease Treatment Modalities

Project No.:	500-90-0050
Period:	September 1990–December 1993
Funding:	$ 200,039
Award:	Contract
Principal Investigator:	Philip J. Held, Ph.D.
Awardee:	The University of Michigan Kidney Epidemiology and Cost Center 315 West Huron, Suite 420 Ann Arbor, MI 48103
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The purpose of this project is to study the cost effectiveness of various treatment modalities for end stage renal disease (ESRD). As expected, transplantation improves survival and is the most cost-effective modality for all age, race, and cause of ESRD groups. Transplantation is not necessarily cost-saving. It is cost-effective because it has the lowest cost per day, but total beneficiary lifetime costs are sometimes increased because of longer patient survival. Center hemodialysis is more cost-effective than is continuous ambulatory peritoneal dialysis (CAPD) among older patients. However, for the youngest age group, CAPD is associated with longer patient survival. Home hemodialysis generally is not more cost-effective than center hemodialysis because of higher costs. There are many qualifications that complicate the interpretation of these results.

Status: The two-volume final report is available from the National Technical Information Service:

- "Cost Effectiveness of ESRD Treatment Modalities: Volume I," accession number PB94-160082, by Philip J. Held, Marc Turenne, Randall Boubjerg, Friedrich Port, *et al.*, contains the text along with summary and example data tables.
- "Cost Effectiveness of ESRD Treatment Modalities: Volume II," accession number PB94-160090, contains detailed descriptive and reference tables with actuarial estimates of beneficiary lifetime costs and survival.

93-007 Delaware Health Care Partnership for Children

Project No.:	11-P-98235/3
Period:	January 1993–July 1994
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Philip Soule
Awardee:	Delaware Department of Health and Social Services 1901 North DuPont Highway New Castle, DE 19720
HCFA Project Officer:	David W. Walsh Division of Health Systems and Special Studies

Description: The Delaware Medicaid-Managed Care Demonstration is a public-private initiative between the State of Delaware and the Alfred I. duPont de Nemours

Foundation (Nemours). Nemours has pledged to develop and maintain 13 pediatric practices/clinics, known as Children's Clinics, in the underserved areas of Delaware. Delaware will enroll Medicaid-eligible children, 17 years of age and under, in the clinics on a capitated basis for up to 1 year. Each clinic will operate like most pediatric/family practices. The clinics will be staffed by board-certified pediatricians, pediatric nurse practitioners, and nursing and office support personnel. Children in all three counties of the State will receive a basic benefit package that includes physician office visits; early and periodic screening, diagnosis, and treatment services; basic lab tests; and certain pharmaceuticals. Only those eligibles living in New Castle County, where the Alfred I. duPont Institute (a pediatric hospital) is located, will have their hospital expenses covered under the capitation.

Status: The State began operations in December 1993. As of August 1994, 2,600 children had been enrolled in the project, and 6 children's clinics had been opened.

92-067 **Demonstration Project on Drug Use Review in Medicaid: Online Prospective Drug Utilization Review**

Project No.:	11-C-90232/7
Period:	September 1992–December 1996
Funding:	$ 1,787,153
Award:	Cooperative Agreement
Principal Investigator:	Betsy Chrischilles, Ph.D.
Awardee:	State of Iowa Division of Medical Services East 13th and Walnut Hoover Building, 5th Floor Des Moines, IA 50319
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of the demonstration is to test the effect of an online prospective drug utilization review system. Iowa will develop and test the system over a 15-month period, followed by a 3-year operational phase. Analyses will address the impact of this intervention on quality of care and on use and costs of prescription drugs and other services. Iowa will test the effect of the system with experimental and control groups via a randomized block design assigning clusters of pharmacies to either intervention or control groups. Iowa has assessed the computer capabilities of State pharmacies and has developed the prospective drug utilization review screens.

Status: This project was implemented in June 1994.

94-088 **Design of a Cost-Effectiveness Protocol for the Morbidity and Mortality in Hemodialysis Clinical Trials**

Project No.:	500-92-0023DO07
Period:	December 1993–November 1994
Funding:	$ 160,752
Award:	Delivery Order in Master Contract
Principal Investigator:	Joel D. Kallich, Ph.D.
Awardee:	The RAND Corporation (See page 214)
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies

Description: The project is developing the research protocol, the methodology and the data collection instruments, and the manuals necessary for a cost-effectiveness analysis of the morbidity and mortality in hemodialysis (MMHD) multicenter, randomized clinical trials. The MMHD clinical trial is testing the efficacy of two different interventions on the hemodialysis prescription—the use of high-flux dialyzers and an increase in the quantity of dialysis as measured by double pool kinetic modeling. RAND will provide methods and instruments for measuring and estimating the cost of hemodialysis and all other medical services to the population in each of the treatment arms of the MMHD clinical trial, instruction manuals and training, and a cost-effectiveness study protocol.

Status: RAND has pilot-tested the draft data collection instruments and is revising them. The final forms and protocol are expected in November 1994.

93-016 **Development of an Automated Caseload Management Decision Support Application for Use in the Women, Infants, and Children Program**

Project No.:	97-P-08079/6
Period:	February 1993–January 1994
Funding:	$ 35,173
Award:	Grant
Principal Investigator:	Arthur W. Burger
Awardee:	Burger, Carroll and Associates, Inc. 1442-B St. Francis Drive Santa Fe, NM 87501

HCFA Project Officer:	Leslie A. Mangels Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The purpose of this project was to continue development of an automated caseload management system for the Supplemental Food Program for Women, Infants, and Children. It allowed managers to target the program to high-risk clients and to improve outreach.

Status: Phase I (development) was completed. A final report has been received. The awardee did not seek Phase II (testing and data gathering) support. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

94-075 Development of a Global Quality Assessment Tool for Managed Care

Project No.:	18-C-90315/9
Period:	September 1994–September 1997
Funding:	$ 1,579,386
Award:	Cooperative Agreement
Principal Investigator:	Elizabeth McGlynn, Ph.D.
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Program Studies

Description: This project will develop and test a clinically based method for assessing the quality of care delivered for a broad range of services in managed care health plans. It will focus on the quality of care delivered to children and women under 45 years of age.

Status: The project is in the initial planning phase.

92-018 Dialyzer Reuse: A Cohort Study

Project No.:	18-C-90045/3
Period:	February 1992–February 1995
Funding:	$ 476,716
Award:	Cooperative Agreement
Principal Investigator:	Harold I. Feldman, M.D.
Awardee:	The University of Pennsylvania School of Medicine Philadelphia, PA 19104-6095
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The study is to determine the impact of reusing hemodialyzer membranes on the health status of end stage renal disease patients undergoing chronic hemodialysis in the United States using the 1986–87 incident cohort. The study is using an intent-to-treat model based on reuse at the 91st day following initiation of dialysis therapy. The analysis uses proportional hazards modeling with patient survival as the primary outcome.

Status: The final analysis files have been created and preliminary results have been generated. A draft report is expected in November 1994.

93-033 Drug Utilization Review Evaluation Contract

Project No.:	500-93-0002
Period:	March 1993–February 1998
Funding:	$ 4,604,856
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this evaluation is to provide generalizable findings on the impacts of retrospective and prospective drug utilization review. Data from the two demonstration States (Iowa and Washington) and information on Medicaid drug utilization review activities from other States will form the basis of the evaluation findings. To test the effects of online prospective drug utilization review and of paying pharmacists for cognitive services on drug problems, drug use and costs, other health services' use and costs, and access to services will be measured. In addition, surveys to pharmacists and

physicians will be conducted to assess changes in the behavior related to the demonstration's interventions.

Status: A Report to Congress describing the first year's activities has been completed. The final evaluation plan and preliminary analysis of the predemonstration period have been completed.

92-017 Economic Barriers to Access to Health Care among the Elderly

Project No.:	17-C-90087/9
Period:	February 1992–October 1994
Funding:	$ 562,453
Award:	Cooperative Agreement
Principal Investigator:	Lee A. Lillard, Ph.D.
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Lawrence E. Kucken Division of Beneficiary Studies

Description: The purpose of this project was to determine the degree to which economic barriers to health care exist within the elderly population. The study identifies socio-economic subgroups among the elderly that may be more or less vulnerable to health services access problems and examines the relationship of health services utilization to economic status, insurance status, household structure, and sources of social support. Analyses are being performed using a data base that links Medicare administrative records with the 1990 Health Supplement to the Panel Study of Income Dynamics.

Status: The analysis phase is nearly completed. The final report will focus primarily on factors affecting Medicare beneficiaries' possession of private supplementary health insurance and its effects on prescription drug and dental care use and expenditures.

93-061 Economic and Cost-Effectiveness Studies for the U.S. Renal Data System

Project No.:	HCFA-IA-9305
Period:	July 1993–June 1998
Funding:	$ 1,657,075
Award:	Interagency Agreement
Principal Investigator:	Philip J. Held, Ph.D.
Awardee:	The National Institute of Diabetes and Digestive and Kidney Diseases c/o: Larry Agadoa, M.D. Building 31 31 Center Drive, MSC 2560 Bethesda, MD 20892-2560
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: This interagency agreement (IAA) provides funds to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to cover the cost of having the coordinating center for the U.S. Renal Data System (USRDS) perform economic and cost-effectiveness studies. NIDDK awarded a contract to the University of Michigan (Philip Held) to be the coordinating center for 5 years from July 1993 to July 1998. The IAA calls for the coordinating center to conduct cost or cost-effectiveness components for at least four existing data studies and for one special study focused on economic issues each year.

Status: The coordinating center is creating cost data sets for special studies and has begun several analyses. One study is looking at the cost associated with comorbidities and another is looking at the determinants of dialyzer membrane use by facilities. Several sections on cost and cost effectiveness were published in the 1994 USRDS *Annual Data Report*.

92-025 Effects of Expanded Medicaid Coverage of Pregnant Women

Project No.:	18-C-90029/4
Period:	February 1992–February 1995
Funding:	$ 650,161
Award:	Cooperative Agreement
Principal Investigator:	Wayne A. Ray, Ph.D.
Awardee:	Vanderbilt University School of Medicine 21st and Garland Nashville, TN 37232
HCFA Project Officer:	Marilyn B. Hirsch, Ph.D. Division of Program Studies

Description: This study will examine the effect of four Medicaid expansions in Tennessee: expanded eligibility for pregnant women and infants up to 100 percent of poverty (enacted July 1, 1987); presumptive eligibility (enacted February 1, 1989); enhanced prenatal care

services (enacted July 1, 1989); and expanded eligibility for pregnant women and infants up to 150 percent of poverty (enacted January 1, 1990). Prenatal care use, birth weight, and infant mortality are the outcomes of interest. Data from Medicaid records, vital statistics, and the Risk Factor Surveillance Program will be used to conduct both strata analysis and multivariate analysis to investigate the effect of each of the expansions separately and over one entire period of implementation.

Status: Creation of the data files for this project and analysis of the data are in progress. Researchers have examined the effect of increasing coverage of pregnant women to 100 percent of the Federal poverty level and of presumptive eligibility. Both interventions had significant effects on Medicaid enrollment and prenatal care use.

91-002 Emergency Room Triage Demonstration Report

Project No.:	95-P-99626/9
Period:	January 1991–March 1994
Funding:	$ 1,500,000
Award:	Grant
Principal Investigator:	Carter Clements, M.D.
Awardee:	Highland General Hospital 1411 East 31st Street Oakland, CA 94608
HCFA Project Officer:	Joseph M. Cramer Division of Hospital Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: In January 1991, the Health Care Financing Administration funded the first year of a 3-year emergency room triage demonstration. The explosive increase in demand for the services of Highland's emergency department has strained severely the resources of this inner city public hospital. The demonstration was mandated by section 6217 of the Omnibus Budget Reconciliation Act of 1989 that provided up to $500,000 in funding per year. Most of the funds have been used for the hiring of mid-level practitioners (MLP) to treat patients needing only minimal services. In addition, patient advocates were hired to ease stress among patients and practitioners in this crisis-laden environment.

Status: The project was fully operational; the MLP triage team, the patient advocate team, and the evaluation group were in place and fully functional in 1993. The use of the MLPs has resulted in increased clinical coverage and patient care in the emergency room. The patient advocate team has produced significant results in reducing the level of tension and patient anger in the waiting room. Several studies on patient and staff satisfaction showed continuing increases in satisfaction with services received and delivered in the emergency department. Other studies showed a significant decrease in the average waiting time for patients to see the triage nurse. In addition, facility changes were made in the acute care clinic, which will provide better patient comfort and allow for more noncritical patients to be seen. A computer system was installed to establish a telephone followup protocol for results of previous visits for medical tests. Another computer system was installed that generates printed patient instructions that the patient can take home. The final report is expected in January 1995.

IM-004 End Stage Renal Disease Annual Research Report

Funding:	Intramural
HCFA Project Director:	Paul W. Eggers, Ph.D. Division of Beneficiary Studies

Description: The annual reports are designed to produce a wide range of data and analyses regarding the end stage renal disease (ESRD) program. Many of the data in these reports emphasize trends and comparisons over time, making these reports standard reference sources illustrating changes in the nature of the Medicare ESRD population and in the pattern of treatment of this population.

Status: The most recent published report is Health Care Financing Administration: *Research Report: End Stage Renal Disease, 1992*. HCFA Pub. No. 03359. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, September 1994. While supplies last, complimentary copies of this report are available from the Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Statistics and Data Management, Division of Information Analysis, Third Floor, Security Office Park Building, 6325 Security Boulevard, Baltimore, Maryland 21207. Telephone requests can be made to (410) 597-5183.

93-021 End Stage Renal Disease Patient-Specific Classification System: A Determinant to the Advancement of Patient Care

Project No.:	97-P-08034/9
Period:	February 1993–January 1994
Funding:	$ 34,998
Award:	Grant

Principal Investigator:	Jeffrey J. Parkinson
Awardee:	Mecon Associates 200 Porter Place, Suite 100 San Ramon, CA 94583
HCFA Project Officer:	Michael J. Baier Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The project focuses on developing a patient classification system for chronic hemodialysis patients that reflect their needs for direct and indirect nursing care time. The awardee worked with the American Nephrology Nurses Association in designing the patient classification system.

Status: Phase I (development) was completed; however, Phase II (product development) was not funded. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-021 End Stage Renal Disease Research Studies

Project No.:	17-C-90085/3
Period:	February 1992–June 1995
Funding:	$ 450,000
Award:	Cooperative Agreement
Principal Investigator:	Philip J. Held, Ph.D.
Awardee:	The University of Michigan Kidney Epidemiology and Cost Center 315 West Huron, Suite 420 Ann Arbor, MI 48103
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The purpose of this project is to perform cost studies of major issues for the end stage renal disease (ESRD) program. The main focus to date has been on dialyzer reuse. An extensive analysis for the period 1989–90 among patients treated in freestanding dialysis units using primarily conventional dialyzers has found a statistical association by showing increased mortality among ESRD patients on in-center dialysis in facilities that reused dialysis filters compared to similar patients in dialysis facilities that did not reuse dialyzers. Work is well-advanced on a methodology to calculate standardized hospitalization rates for dialysis facilities. Ongoing studies include an analysis of the dialysis facility cost reports, data, cost effectiveness of treatment modalities, dialysis unit inspection data, and dialyzer reuse and causes of hospitalization.

Status: Several papers funded in whole or in part have been published in professional journals during 1994. They are: "Association of Dialyzer Reuse Practices and Patient Outcomes" in the *American Journal of Kidney Diseases*; "Effect of Race on Access to Recombinant Human Erythropoietin in Long-Term Hemodialysis Patients" in *The Journal of the American Medical Association*; and "The Impact of HLA Mismatches on the Survival of First Cadaveric Kidney Transplants" in *The New England Journal of Medicine.*

94-118 Estimating Mammography Utilization by Elderly Medicare Women for Whom the Health Care Financing Administration Does Not Receive Administrative Claims

Project No.:	500-92-0020DO11
Period:	September 1994–June 1994
Funding:	$ 110,074
Award:	Delivery Order in Master Contract
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Anne A. Trontell, M.D. Division of Beneficiary Services

Description: This delivery order will provide basic information relevant to the use of the Health Care Financing Administration's (HCFA) data in HCFA's Consumer Information Initiative. Information developed under this delivery order will assist in understanding potential deficiencies in HCFA's administrative claims data for measuring mammography utilization. HCFA wants to know the utilization of mammography by its elderly female beneficiaries for both programmatic and public health reasons. Utilization patterns can be used to direct both HCFA and the Public Health Service (PHS) outreach efforts to increase the use of mammography; help track the mammography screening objectives of the PHS Healthy People 2000; and contribute to the health

services research goals of the Secretary's National Breast Cancer Action Plan.

Status: This project is in the early developmental stage.

92-052 Evaluation of Capitation Payment for End Stage Renal Disease Services

Project No.:	500-92-0023DO03
Period:	September 1992–December 1993
Funding:	$ 239,056
Award:	Delivery Order in Master Contract
Principal Investigator:	Donna O. Farley, Ph.D.
Awardee:	The RAND Corporation (See page 214)
HCFA Project Officer:	Paul W. Eggers, Ph.D. Division of Beneficiary Studies
Mandate:	Social Security Act, section 1875 (Public Law 103-66)

Description: The purposes of this project are to develop a capitation payment system for services provided to end stage renal disease (ESRD) patients and to perform a preliminary evaluation of the financial implications of such a payment system on the Medicare ESRD program and on the health plan serving ESRD patients. The work addresses several considerations that are central to the design of a capitation payment system for ESRD services. These include incentives for appropriate service use, control of program costs, and patient and provider participation; selection of services to be included in the capitation; and methods to adjust capitation payments for financial risks.

Status: The proposed capitation system uses four payment components consisting of monthly capitation payment rates to cover health services for individuals who are on dialysis treatment or who have functioning kidney grafts and lump-sum payments that cover expected incremental costs of kidney transplantations or graft failure events. Monthly capitation payments are risk-adjusted, and fixed loss outlier payments for unusually expensive patients are provided. Alternative geographic adjusters to convert the standardized amounts to health plan payments also were evaluated. The payment methodology explained 25 percent of variation in total annual payments per patient. Risk adjustment of dialysis capitation payments explained only a small portion of variation in individual patients' average monthly expenses, although it did capture substantial variation across patient groups. Outlier payments reduced health plan risk by as much as 15 percent. Design issues included payment subsidies created by the method to define payment component service periods, effects of geographic payment adjustments on distribution of payments, and urban and rural payment differentials. Results from this study are included in "Designing a Capitation Payment Plan for Medicare End Stage Renal Disease Services" (RAND Publication No. MR-391-HCFA) by Donna O. Farley, Joel D. Kallich, Grace M. Carter, Thomas W. Lucas, *et al.* Copies can be obtained from RAND, 1700 Main Street, Post Office Box 2138, Santa Monica, California 90407-2138.

93-023 Evaluation of a Computerized Program That Automatically Assigned Resource-Based Relative Value Scale Codes

Project No.:	97-P-08062/1
Period:	February 1993–January 1994
Funding:	$ 35,000
Award:	Grant
Principal Investigator:	Enzo V. DiGiacomo, M.D.
Awardee:	Medical Horizons, Inc. 136 Dwight Road Longmeadow, MA 01106
HCFA Project Officer:	Leslie A. Mangels Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The purpose of this project is to design and validate *Chart Coder*, a computer program developed by Medical Horizons, Inc. This software automatically assigns a resource-based relative value scale visit code to emergency department patient records.

Status: Phase I (development) was completed. A final report has been received. The awardee did not seek Phase II (product development) support. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-069 Evaluation of the Demonstration for Improving Access to Care for Pregnant Substance Abusers

Project No.:	500-92-0049
Period:	September 1992–September 1997
Funding:	$ 2,131,844
Award:	Contract

Principal Investigator:	Embry Howell, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Edward T. Hutton, Ph.D. Division of Health Systems and Special Studies

Description: The awardee is conducting an evaluation of the demonstration to improve access to Medicaid care for pregnant substance abusers. The demonstration is being implemented in Maryland, Massachusetts, New York, South Carolina, and Washington. The purposes of these projects are to improve outreach and assessment; expand, integrate, and coordinate program services; and improve client case management. The objective of the evaluation is to assess the effectiveness of interventions that are included in the demonstration projects. The evaluator will be responsible for reporting on the implementation process of the demonstration and on the demonstration's effect on access to prenatal care, substance abuse treatment services, and other relevant services. The evaluation will assess the effects of services on the health of drug-addicted pregnant women, any prevention or reduction of short-term impairments to their infants, and the impact on birth outcomes. The evaluation also will compare the cost of substance abuse treatment in residential facilities versus ambulatory care facilities.

Status: The awardee has prepared a final evaluation design and data collection instrument and has implemented data collection. Site visits are being used to assess the status of the implementation of the demonstration, negotiate with providers for implementing the survey, and collect data for the process analysis. Annual reports are being prepared throughout the contractual period.

92-053 Evaluation of Demonstration to Provide Medicaid Coverage for Human Immunodeficiency Virus-Positive Individuals

Project No.:	500-87-0028TO17
Period:	September 1992–January 1994
Funding:	$ 250,000
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Craig Thornton, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 216)
HCFA Project Officer:	Deborah C. Van Hoven Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: No State Medicaid agency responded to the solicitation released in November 1992 to solicit sites for the mandated demonstration to provide Medicaid coverage for human immunodeficiency virus (HIV)-positive individuals. However, Mathematica's contract was modified to provide for a 12-month effort to derive information about State Medicaid coverage of individuals with HIV infection and acquired immunodeficiency syndrome (AIDS). The awardee is undertaking two separate studies under the modified contract. The first study examines the current service delivery systems for persons with HIV/AIDS in Georgia, Illinois, Pennsylvania, and Texas. The second study addresses the current status and features of the 15 State Medicaid waiver programs for persons with AIDS. The awardee will examine seven of these States that have been, or are in the process of being, renewed in order to understand the changes that are being made to the programs during the renewal process and why.

Status: The modification of the existing evaluation contract was implemented in early 1993. Site visits have been made to each of the four States selected as part of the first study. The awardee included these findings in a final report on the first study. Descriptive information has been compiled for the second study, which was included in the final report on the second study. The awardee submitted the final report in July 1994.

91-015 Evaluation of the Medicaid Extension Demonstrations (Formerly, Evaluation of the Medicaid Expansion Demonstrations)

Project No.:	500-87-0030TO10
Period:	June 1991–March 1995
Funding:	$ 927,357
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates Inc. (See page 216)
HCFA Project Officer:	Paul J. Boben, Ph.D. Division of Health Systems and Special Studies

Mandate: Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: For this project, the awardee will design and conduct the evaluation of three demonstrations mandated under section 6407 of the Omnibus Budget Reconciliation Act of 1989. The awardee will evaluate alternative models for extending health insurance coverage to children under 20 years of age who lack insurance. The States conducting the demonstrations are Florida, Maine, and Michigan. Each State will use a different strategy for providing the new coverage. Florida will test the effectiveness of marketing a school-based affordable insurance package that delivers services through a managed care network. Maine will conduct a statewide program that subsidizes comparable private employer-based group coverage, where such insurance is shown to be cost effective. Michigan will test the effectiveness of a public/private partnership between the State and Michigan Blue Cross and Blue Shield, using donated funds to subsidize a mainstream outpatient insurance package. The evaluation will determine the effect of these demonstrations on various outcome and process measures of access to care, private insurance coverage, and cost of care. Methodology to be used will take into account the distinctiveness of the three demonstrations while incorporating a strategy that will allow for comparisons between programs in terms of performance in penetrating the eligible population. Case studies will be coupled with the analysis of program data to describe the structure and processes of the demonstrations. In addition, primary data will be collected through surveys of both program participants and controls. Separate analyses of program costs and program effectiveness will be included.

Status: The Health Care Financing Administration has received from Abt Associates Inc. the most recent draft interim report, dated September 1, 1994. The report contains comparisons among the three demonstration sites of enrollment and utilization, based on enrollment, claims, and encounter data obtained from the sites. Results from the demonstration sites also were evaluated, based on comparable measures derived from the National Health Interview Survey. Preliminary statistical analysis of the effect of the demonstrations on access, utilization, out-of-pocket expenditures, and satisfaction was included, as were case study reports on all three demonstration sites (reflecting the outcomes of recent site visits to Michigan and Florida). The second wave of telephone interviews is the next major task to be accomplished.

92-064 Evaluation of the Medicaid Uninsured Demonstrations

Project No.: 500-92-0062
Period: September 1992–September 1996
Funding: $ 1,313,458
Award: Contract
Principal Investigator: Margo L. Rosenbach, Ph.D.
Awardee: Health Economics Research, Inc. (HERI)
300 Fifth Avenue, 6th Floor
Waltham, MA 02154
HCFA Project Officer: James P. Hadley
Division of Health Systems and Special Studies

Mandate: Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this contract is to design and conduct the evaluation of three demonstration projects being conducted in Maine, South Carolina, and Washington State. These demonstrations, implemented in response to a congressional mandate under section 4745 of the Omnibus Budget Reconciliation Act of 1990, are intended to test the effect of allowing States to extend Medicaid coverage to low-income families. Evaluation contract deliverables will include a series of annual reports, an interim and a final Report to Congress, and a final evaluation report. The evaluator will examine within and between site processes and outcomes, including the:

- Ability of the programs to enroll significant numbers of eligible persons.
- Conditions under which eligible persons and their families are willing to participate in such programs, given their scarce financial resources.
- Ability of the programs to induce adequate numbers of providers to ensure the availability of necessary services at appropriate levels of utilization.
- Willingness of employers to participate in the programs and the conditions under which they do or do not choose to do so.
- Program's effect on service utilization and health outcomes of participants.
- Cost effectiveness of such programs for the various public and private interests.
- Extent to which the demonstration's interventions could be applied nationally to assist in achieving program goals.

Status: The evaluator conducted an initial series of site visits during 1993. Their first annual report uses data collected during these site visits and data from

State-administered baseline surveys to describe the implementation phase and early operational phase of the demonstrations. A second series of site visits is scheduled for late 1994 and will examine process issues for the first operational year of the demonstrations. The first wave of the evaluation conducted a survey, to be completed during 1994, which will provide information on participants' health status, reasons for enrolling in the demonstration, and satisfaction with the programs.

93-076 Examination of the Medicaid Expansions for Children

Project No.:	500-93-0042
Period:	September 1993–March 1996
Funding:	$ 648,416
Award:	Contract
Principal Investigator:	Genevieve Kenney, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Marilyn B. Hirsch, Ph.D. Division of Program Studies

Description: This project will focus on Medicaid eligibility expansions for children. These expansions were legislated as part of the Omnibus Budget Reconciliation Acts of 1989 and 1990. Analyses on the impact of the expansions include examination of enrollment and expenditure trends from 1988 to 1992; assessment of the extent to which the expansions penetrated the target population; and multivariate analysis to examine the impact of State policies and the eligibility group on enrollment, expenditures, and utilization of services. Steps to examine access to care and utilization of services include the development of a theoretical model, an analysis plan, and items that could be incorporated into an established national survey.

Status: Construction of data bases has begun. A review of proposed health reform bills and how they affect children has been prepared.

91-010 Expert System for Medical Review

Project Nos.:	500-91-0033 (Phase I) 97-P-08039/3 (Phase II)
Period:	June 1991–December 1991 (Phase I) September 1992–September 1993 (Phase II)
Funding:	$ 34,800 (Phase I) $ 98,240 (Phase II)
Award:	Contract (Phase I) Grant (Phase II)
Principal Investigator:	Robert D. Smith
Awardee:	Columbia Cascade, Inc. 12030 Sunrise Valley Drive, Suite 440 Reston, VA 22091-3409
HCFA Project Officer:	Carl S. Hackerman Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project used available expert systems software for microcomputers to assist in determining and completing medical review procedures that are performed by insurance claims handling firms.

Status: Phase II (testing and data gathering) was completed in March 1994. The end product is a software package that can serve as a medical review advisor for claims processed under the Medicare program. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

91-009 Expert-System Software for Quality Assessment

Project Nos.:	500-91-0031 (Phase I) 97-P-08017/9 (Phase II)
Period:	June 1991–December 1991 (Phase I) September 1992–September 1994 (Phase II)
Funding:	$ 24,000 (Phase I) $ 164,100 (Phase II)
Award:	Contract (Phase I) Grant (Phase II)
Principal Investigator:	John Rafferty, Ph.D.
Awardee:	John Rafferty and Associates 14012 North 80th Place Scottsdale, AZ 85260
HCFA Project Officer:	Carl S. Hackerman Office of Operations Support

Mandate: Small Business Innovation Development Act of 1982
(Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project developed a microcomputer software package that provides technical support for health care quality assessments. It attempts to fill gaps in the technical knowledge of staff responsible for quality assessments. It also assists in defining useful questions for study, helps review research design alternatives; reviews possible sampling techniques; discusses randomness (and assists with random selection of samples); and helps with the analyses, display, and interpretation of results. During Phase I, the awardee developed the data display portion of the final proposed product (a graphics module) and has been able to market that portion by itself.

Status: Phase II (testing and data gathering) has been completed. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

90-037 Extending Medicaid Coverage of Substance Abuse Treatment to Eligible Pregnant Women: Assessment of Issues and Costs

Project No.:	99-C-98526/1
Period:	August 1990–December 1993
Funding:	$ 168,551
Award:	Cooperative Agreement
Principal Investigator:	Mary Jo Larson, Ph.D.
Awardee:	Brandeis University
	(See page 202)
HCFA Project Officer:	Marilyn B. Hirsch, Ph.D. Division of Program Studies

Description: The purposes of this project are to study Medicaid's coverage of substance abuse treatment programs and to assess the costs of expanding this treatment to substance-abusing pregnant women at risk of delivering a substance-impaired infant. This project used data from surveys, previous studies, and interviews with State officials working in the areas of Medicaid and substance abuse. Medicaid cost estimates for California, Massachusetts, New York, South Carolina, Texas, and Washington were developed.

Status: The final report, "Cost Estimates for Expanded Substance Abuse Benefits for Medicaid-Eligible Pregnant Women," accession number PB94-168010, is available from the National Technical Information Service. The researchers developed a simulation model to estimate new Medicaid expenditures in six States that adopted or expanded Medicaid benefits to the population of substance abusing pregnant women. The scenarios that were modeled include:

- Expanded outreach to substance abusing women not in prenatal care.
- Expanded substance abuse screening of women in prenatal care programs.
- Increased Medicaid participation by outpatient treatment programs serving pregnant women.
- Increased reimbursement to providers.
- Increased Medicaid participation by residential treatment programs.
- Combined strategies.

The researchers suggest that the first three are likely strategies for most State Medicaid programs.

94-105 Extension of Medicaid Benefits for Post-Partum Women

Project No.:	11-W-00007/4
Period:	January 1994–December 1998
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Robert Ehrlich
Awardee:	South Carolina State Health and Human Services Finance Commission P.O. Box 8206 Columbia, SC 29202-8206
HCFA Project Officer:	Alisa Adamo Division of Health Systems and Special Studies

Description: South Carolina's Extension of Medicaid benefits for Post-Partum Women seeks to increase the amount of time between pregnancies by extending and expanding family planning services to post-partum women. Under current law, if a woman is Medicaid-eligible only because of her pregnancy (her income is otherwise too high), Medicaid family planning benefits continue for 60 days after giving birth. In this project, South Carolina is extending coverage for an additional 22 months. The project is expected to serve approximately 20,000 women a year. Women whose family income is at or below 185 percent of the Federal poverty level at the time of giving birth are eligible for a

defined set of family planning services during the additional 22-month period, without regard to subsequent changes in income level. South Carolina will evaluate the project by using State vital records and Medicaid Management Information Systems data to do trend analyses within comparable populations to measure the effect of the demonstration. Measures will include pregnancies averted or postponed and improvement in birth outcomes (e.g., reductions in premature births, low-birth weight, and neonatal intensive care unit cases).

Status: The project became operational on July 1, 1994.

93-046 Feasibility Study to Develop a Multistate Medicaid Reciprocity Program for Migrant and Seasonal Farm Workers

Project No.:	500-92-0037DO02
Period:	June 1993–October 1994
Funding:	$ 331,089
Award:	Delivery Order in Master Contract
Principal Investigator:	George E. Wright, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 205)
HCFA Project Officer:	Sherrie L. Fried Division of Health Systems and Special Studies

Description: The Health Care Financing Administration has implemented a feasibility study of Medicaid eligibility under a multistate reciprocity program for migrant and seasonal farm workers. A background paper will identify residency requirements, claims and administrative procedures, existing migrant health centers, and barriers to migrant health care for States in the eastern and midwestern migrant streams. An issue paper will determine whether the development of a reciprocity program in the eastern and midwestern streams would be feasible. If sufficient State interest exists and the establishment of multistate reciprocity agreements is determined to be feasible, a demonstration design will be developed.

Status: Mathematica Policy Research, Inc. (MPR), was given a no-cost extension through October 29, 1994. MPR prepared an issue paper describing various options for a multistate reciprocity program. The recommended option utilized interstate transfer of eligibility for migrants. MPR is developing a demonstration design and a model memorandum of agreement for participating States. Significant State interest exists to further explore the possibility of a demonstration.

91-008 Feasibility Study of a Pharmaceutical Case Management Program to Control Costs and Increase Quality Outcomes of Pharmaceutical-Related Care

Project Nos.:	500-91-0035 (Phase I) 97-P-08047/1 (Phase II)
Period:	June 1991–December 1991 (Phase I) September 1992–March 1994 (Phase II)
Funding:	$ 35,771 (Phase I) $ 99,933 (Phase II)
Award:	Contract (Phase I) Grant (Phase II)
Principal Investigator:	M. Lee Morse
Awardee:	Mikalix and Company 404 Wyman Street, Suite 375 Waltham, MA 02154
HCFA Project Officer:	Carl S. Hackerman Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project developed a pharmaceutical case management software product that will identify and intervene in inappropriate pharmaceutical therapies for the elderly.

Status: Phase II (testing and data gathering) was completed in March 1994. The end product is a software package entitled CASEMED™. This software is designed to provide support and standardization to the pharmaceutical case management process. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

93-070 Federally Qualified Health Centers

Project No.:	500-92-0037DO03
Period:	September 1993–March 1995
Funding:	$ 283,465
Award:	Delivery Order in Master Contract
Principal Investigator:	Judith Wooldridge
Awardee:	Mathematica Policy Research, Inc. (See page 205)
HCFA Project Officer:	Alisa Adamo Division of Health Systems and Special Studies

Description: The purpose of this study is to address how and why Medicare and Medicaid patients access federally qualified health centers (FQHC), what types of utilization patterns have emerged, and what impact the FQHC program has had on Medicaid and Medicare costs. Because FQHC services utilization data are not readily available in a central data base, the first phase of the contract was to determine the feasibility of doing a valid quantitative study. This phase has been completed, and the contractors have determined that adequate data can be drawn from Medicaid claims data. The contractors now are completing the study design, which will encompass a pre-post design utilizing data from approximately two or three States from 1988 through 1992. The study also will examine the relationship between FQHCs and Medicaid-managed care plans in the selected States. The FQHC legislation requires a State to include FQHC services in its State Medicaid plan and to reimburse FQHCs on a cost basis. Many States have been struggling with how to integrate FQHCs in their Medicaid-managed care programs. The impact of FQHCs providing preventive services to Medicare beneficiaries is also an area of interest to the Health Care Financing Administration, since Medicare covers only a limited number of preventive services outside the FQHC setting. However, the awardee has determined that it is not feasible to assess the impact of this benefit expansion.

Status: The study design is being finalized.

94-068 Florida Welfare Reform: Family Transition Program

Project No.:	11-W-00011/4
Period:	January 1994–December 2001
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	H. James Towey
Awardee:	Florida Department of Health and Rehabilitative Services 1317 Winewood Boulevard Tallahassee, FL 32399-0700
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Health Care Financing Administration and the Administration for Children and Families to:

- Allow two-parent families to have the same eligibility criteria as single-parent families and disregard the income of stepparents for the first 6 months of receipt of Aid to Families with Dependent Children (AFDC).
- Impose financial sanctions on families if children do not attend school regularly or are not immunized.
- Limit the receipt of AFDC benefits to 24 months in any 60-month period.
- Require recipients whose youngest child is over 6 months of age to participate in the Job Opportunities and Basic Skills program.
- Increase disregard of earnings and asset limits.
- Increase transitional child care benefits.
- Eliminate quarterly income reporting during the Medicaid transition benefit period, but require recipients to report income increases.

Status: This project is in the early implementation phase.

94-015 Health Care Technology Analysis Files and Data Summary

Project No.:	500-94-0014
Period:	June 1994–December 1994
Funding:	$ 37,539
Award:	Contract
Principal Investigator:	Sharon G. Downey
Awardee:	Shepard Patterson Government Systems Division 8300 Colesville Road, Suite 350 Silver Spring, MD 20910
HCFA Project Officer:	Lawrence E. Kucken Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: The purpose of this project is to produce a set of health care technology analysis files (HCTAF) to be used in monitoring diffusion rates of emerging health care technologies. These files are being constructed from procedure codes contained in the Health Care Financing Administration's (HCFA) National Claims History file and from Medicare enrollment data contained in HCFA's denominator file. Initially, the HCTAF will cover the years 1991 through 1993. The summary data will include an initial descriptive analysis of diffusion rates for this period.

Status: File construction is in the early developmental stage.

94-119 Health Risk Appraisal for Older Persons

Project No.:	17-C-90300/9
Period:	September 1994–September 1996
Funding:	$ 250,000

Award:	Cooperative Agreement
Principal Investigator:	Lester Breslow, M.D.
Awardee:	University of California, Los Angeles School of Public Health 1100 Glendon Avenue, Suite 711 Los Angeles, CA 90024-3511
HCFA Project Officer:	Joan L. Warren, Ph.D. Division of Beneficiary Studies

Description: The project will expand on existing work to develop a method to reduce behavioral risk factors among elderly people, which may reduce the frequency and extent of functional impairment. In previous work, the awardee developed a self-administered health risk appraisal that identified specific behavioral risk factors. This project will refine the existing survey instrument for use with elderly people. The final product will include a questionnaire, software developed for the questionnaire, feedback on algorithms and related software needed to produce personalized reports for participants and their physicians, documentation for the system, and instructions that can be given to participants and their physicians on how to use the system and to interpret the results.

Status: The cooperative agreement was awarded on September 28, 1994. This project is in the developmental phase.

IM-027 Hospitalizations with Dehydration among the Elderly Medicare Population

Funding:	Intramural
HCFA Project Director:	Joan L. Warren, Ph.D. Division of Beneficiary Studies

Description: Dehydration, a common condition of the elderly, is one of the 10 most frequent diagnoses reported on Medicare hospital claims. An analysis of Medicare beneficiaries hospitalized with dehydration in 1991 described the demographic characteristics of these persons and the comorbid conditions associated with dehydration. Additional analyses were performed to determine the risk factors associated with hospitalization with dehydration and the risk factors associated with mortality following hospitalization with dehydration.

Status: "The Burden and Outcomes Associated with Dehydration among U.S. Elderly, 1991" report was published in the August issue of the *American Journal of Public Health* 84:1265-1269, 1994. Further studies of risk factors for dehydration are being done in collaboration with the National Institute on Aging.

94-039 Hospital Obstetrical Care: A Comparison of Quality Indicators in Medicaid Fee-for-Service and Medicaid-Managed Care Groups

Project No.:	18-C-90429/5
Period:	September 1994–September 1996
Funding:	$ 257,681
Award:	Cooperative Agreement
Principal Investigator:	Denise M. Oleske, Ph.D.
Awardee:	Rush University 1653 West Congress Parkway Chicago, IL 60612-3833
HCFA Project Officer:	Marilyn B. Hirsch, Ph.D. Division of Program Studies

Description: The objectives of this study are to describe and ascertain differences in the prevalence of clinical quality indicators in Medicaid fee-for-service, Medicaid-managed care, and private-managed care groups for maternal and child hospital obstetrical care. Data from California and Florida will be used. Data sources for this project include birth and fetal death certificates, hospital discharge abstracts, Medicaid eligibility files, and the American Hospital Association Annual Survey.

Status: The project is in the early developmental phase.

93-028 Hypermedia-Based Health Insurance Counselor Performance Support System

Project No.:	97-P-08042/5-01 (Phase I) 97-P-08042/5-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 34,999 (Phase I) $ 118,719 (Phase II)
Award:	Grant
Principal Investigator:	Sara Derenge
Awardee:	Technovation Training, Inc. Executive Court Professional Centers 3454 Oak Alley Court, Suite 209 Toledo, OH 43606-1317
HCFA Project Officer:	Leslie A. Mangels Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project seeks to facilitate consistency among statewide efforts in terms of the State's capability to train and support the performance of volunteers and others who will provide this counseling.

Status: Phase I (development) was completed. The project is in Phase II (testing and data gathering). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-016 Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program

Project No.:	17-C-90094/3
Period:	February 1992–December 1994
Funding:	$ 334,040
Award:	Cooperative Agreement
Principal Investigator:	Peter J. Neumann, Ph.D.
Awardee:	The People-to-People Health Foundation, Inc. Center for Health Affairs 7500 Old Georgetown Road, Suite 600 Bethesda, MD 20814-6133
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Program Studies

Description: This study of the Qualified Medicare Beneficiary (QMB) program introduced by the Medicare Catastrophic Coverage Act of 1988 uses data from the Medicare Current Beneficiary Survey and the 1990 Population Census to estimate the magnitude of enrollment and nonenrollment. The project produces national estimates of the size and characteristics of the elderly populations enrolled and not enrolled in the QMB program; identifies the most significant barriers to program participation and the most frequent sources of information that would facilitate participation; and develops a methodology for identifying local areas where nonenrollees are most likely to reside and where outreach programs tailored to the needs and preferences of different subpopulations of poor elderly might be effective.

Status: Analyses of Medicare utilization by QMBs in the sample are under way. Two volumes of the three-volume final report have been received: Neumann, P., Bernardin, M., Boyer, E., and Evans, W.: "Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program." Bethesda, Maryland, August 23, 1994; and Neumann, P., Bernardin, M., Boyer, E., and Evans, W.: "Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program. Appendix C: The Mapping Project," Bethesda, Maryland, August 30, 1994.

94-109 Identifying Drug Therapy Inappropriateness: Determining the Validity of Drug Use Review Screening Criteria

Project No.:	18-C-90302/3
Period:	September 1994–August 1996
Funding:	$ 209,428
Award:	Cooperative Agreement
Principal Investigator:	Ilene Zuckerman, Pharm.D.
Awardee:	The University of Maryland at Baltimore Center on Drugs and Public Policy School of Pharmacy 511 West Lombard Street Baltimore, MD 21201
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Beneficiary Studies

Description: The purpose of this study is to determine if outpatient drug use review (DUR) screening identifies clinically significant cases of inappropriate drug prescribing in the Medicaid program. The objectives of the study are to:

- Quantify the agreement between a DUR screening of Maryland Medicaid claims data with the medical record.
- Test the hypothesis that cases of appropriate antihypertensive drug therapy are associated with lower mean blood pressures.
- Outline a method to establish standards of acceptable variation from the drug therapy inappropriateness criteria for drugs used to treat hypertension.
- Produce a manual for Medicaid DUR programs on assembling a minimal data set to permit an ongoing assessment of the usefulness of DUR screening of Medicaid claims data.

Status: The study is in the developmental phase.

93-042 Illinois Welfare Reform: Homeless Families Stabilization (Formerly, Illinois Homeless Families Stabilization)

Project No.:	11-P-90242/5
Period:	May 1993–June 1998
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Robert Wright

Awardee:	Illinois Department of Public Aid 100 South Grand Avenue East Springfield, IL 62762-0001
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Health Care Financing Administration and the Administration for Children and Families. The Illinois demonstration provides "one-stop-shopping" for services for homeless families who are eligible for Aid to Families with Dependent Children; increases the asset limit and the disregard of earnings in the first 2 years of employment; and provides a 24-month Medicaid transition benefit with no income limit for those cases who work their way off welfare.

Status: Demonstration waivers were implemented on July 1, 1994.

92-020 Impact of Complicating Diseases on End Stage Renal Disease Outcomes and Costs

Project No.:	17-C-90082/3
Period:	February 1992–December 1994
Funding:	$ 321,044
Award:	Cooperative Agreement
Principal Investigator:	Neil Powe, M.D.
Awardee:	The Johns Hopkins University School of Medicine 720 Rutland Avenue Baltimore, MD 21205
HCFA Project Officer:	Lawrence E. Kucken Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The purpose of this project is to examine patient and provider characteristics associated with complicating diseases within the end stage renal disease (ESRD) population, and the effects of these disease patterns on patient outcomes, utilization, and costs. The study design involves longitudinal analyses of ESRD patients to determine risk factors associated with the onset of complicating illness and outcomes such as hospitalization and mortality. The study period covers the years 1984–90 and will draw upon data from the ESRD Program Management and Medical Information System and other Medicare statistical files.

Status: Construction of the analysis files has been completed and the data analysis phase is under way.

92-031 Impact of the Medicare Fee Schedule on Access to Physician Services

Project No.:	17-C-90037/1
Period:	March 1992–February 1995
Funding:	$ 768,498
Award:	Cooperative Agreement
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Renee Mentnech Division of Beneficiary Studies

Description: The purpose of this project is to evaluate the impact of the Medicare fee schedule (MFS) on access to care. A sample of beneficiaries will be selected for study from six strata reflecting the size of the payment change under the MFS. Access for vulnerable segments of the population will be measured both in terms of utilization and outcomes, as well as financial liability. National trend data also will be developed. In addition, changes in regular source of care and difficulties obtaining care also will be assessed using the Medicare Current Beneficiary Survey (MCBS).

Status: A nationally representative sample has been drawn, and Medicare utilization data have been assembled for the sample. Measures of outcomes (such as admissions for ambulatory care sensitive conditions) and utilization (such as use of preventive services) have been developed for vulnerable groups and for geographic areas by expected MFS payment change. The 1991 outcome measures were compared with the 1992 data to identify any changes in the first year of the MFS. In future analyses, utilization measures for 1991 will be compared to 1992. Substantial differences between vulnerable population subgroups were identified. Preliminary results suggest, however, that access neither worsened nor improved during the first year of MFS implementation. Access measures from Rounds 1 and 4 of the MCBS (1991 and 1992 data, respectively) have been developed. These access measures will be compared with 1993 data from Round 7 to identify whether changes have occurred. Results from this project have been incorporated into the 1993 and 1994 Reports to Congress on access.

89-024 **Impact of Prescription Drug Coverage for Aged Medicare Beneficiaries** (Formerly, An Analysis of the Impact of Prescription Drug Coverage for Aged Medicare Beneficiaries)

Project No.:	17-C-99392/3
Period:	August 1989–September 1993
Funding:	$ 889,741
Award:	Cooperative Agreement
Principal Investigator:	Bruce Stuart, Ph.D.
Awardee:	Gerontology Center College of Health and Human Development Penn State University 210 Henderson Building South University Park, PA 16802
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Program Studies

Description: The Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) is available to residents who are not covered by Medicaid and who have incomes of less than $13,000 for single persons and $16,200 for married couples. The final report is comprised of six interrelated analyses: profiles of prescription drug use by PACE beneficiaries, dynamic aspects of prescription drug use by PACE enrollees, patterns of use of prescription drugs and Medicare services as death approaches, insurance and the demand for prescription drugs, incidence of drug utilization review violations in the PACE population, and outcomes associated with violation of drug utilization review screening criteria.

Status: The study found that prescription drug utilization by PACE enrollees is higher than that reported in national survey estimates for the U.S. elderly because only half of the elderly who met the financial criteria actually enrolled in PACE. Those who enroll are in poorer health and use more prescription medicine than do the elderly in general. Women comprise about three-quarters of the PACE enrollees, similar to that reported in national surveys. PACE-enrolled women use on average 26 prescriptions annually, about three to four more than do PACE-enrolled men. Despite the higher average number of prescriptions, the average billed charge per PACE claim for women is about a dollar less than that for men, $24.81 versus $25.72, respectively. The mean annual prescription drug expense per PACE beneficiary more than doubled between 1985 and 1990, from $303.87 to $640.47. There has been a marked increase in prescription charges over time, averaging about 10 percent per year, exceeding the increase in the overall Consumer Price Index. Stuart, B., Ahern, F.M., and Coulson, N.E., in their report, "The Impact of Prescription Drug Coverage on Aged Medicare Beneficiaries, January 1994," conclude that physicians are prescribing relatively more costly drugs to PACE beneficiaries than they were in the past. The combined effect of increased utilization and rising drug prices is a dramatic increase in annual spending for prescription drugs. The analysis of survey data on 4,066 elderly Pennsylvania Medicare beneficiaries presents consistent and unambiguous evidence that insurance coverage for prescription drugs is associated with increased demand. The authors conclude that the outcomes analyses provide strong evidence that prescribing problems result in some adverse clinical outcomes and in increased health service utilization. The results of the benzodiazepine screen violation analysis support the literature that repetitive duplicative use of benzodiazepines, the concurrent use with other anxiolytics, and excessive dosage are significantly associated with adverse drug reactions. However, the authors were unable to confirm the literature-reported association of fractures of the femur with excessive use of benzodiazepines or the use of long half-life benzodiazepines.

92-010 **Impacts of Medicaid Eligibility Expansions and Innovative Programs for Maternal Health Care**

Project No.:	18-C-90113/9
Period:	February 1992–December 1994
Funding:	$ 301,000
Award:	Cooperative Agreement
Principal Investigator:	Stephen H. Long, Ph.D.
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Marilyn B. Hirsch, Ph.D. Division of Program Studies

Description: The focus of this project is on the impacts of the eligibility expansion on the financing and use of health care services by all women and newborns in Florida, regardless of their source of insurance, if any. The analytic approach to be taken is to estimate the flow of funds for perinatal care before and after the Medicaid expansions to assess the aggregate impacts of the changes.

Status: Researchers have received extensive data from Florida to carry out the project. Linked data sets have been created. Analysis is ongoing.

91-034 Implementing Findings on Volume and Quality

Project No.:	99-C-98526/1
Period:	August 1991–December 1992
Funding:	$ 115,181
Award:	Cooperative Agreement
Principal Investigator:	Joel Cohen
Awardee:	Brandeis University (See page 202)
HCFA Project Officer:	Gerald F. Riley Division of Beneficiary Studies

Description: The purpose of this study is to provide a descriptive analysis of the distribution, by hospital, of Medicare cases for selected procedures and services. Researchers will provide data on the feasibility of concentrating certain procedures among a limited number of hospitals. Interest in this "regionalization" of certain procedures follows from previous studies that indicate better patient outcomes are associated with hospitals that perform high volumes of the procedures. National statistics will provide information on the number of hospitals doing the procedures and the range of volumes across these hospitals. Breakdowns by hospital characteristics will indicate whether there seems to be a low-volume problem for any particular type of hospital. Market-level statistics on the distribution of procedures across hospitals will provide information on the extent to which regionalization may be feasible. Because any regionalization involves some reduction in access, it is important to document the magnitude of this effect. The distribution of surgeon volumes also will be studied for the State of Alabama. Linking surgeon and hospital volume data will permit the examination of the relationship between surgeon and hospital volumes. The primary source of data will be the Medicare provider analysis and review file records for hospital stays occurring in 1987 and 1990. These data will be merged with metropolitan statistical area identifiers, the area resource file, and an American Hospital Association survey. Data from all Part B physician claims for the State of Alabama will be used for the analysis of surgeon volumes. The study's investigators also will identify alternative strategies for promoting regionalization.

Status: A draft report was received in December 1993. Comments on the draft report were provided by the Health Care Financing Administration in January 1994. The analysis of surgeon volumes has not yet been conducted.

93-024 Improved Selection of Antibiotic Therapy during Hospitalization with Urinary Tract Infections

Project No.:	97-P-08078/2
Period:	February 1993–January 1994
Funding:	$ 41,930
Award:	Grant
Principal Investigator:	Renee J. Goldberg Arnold
Awardee:	Pharmacon International, Inc. 350 Fifth Avenue, Suite 5110 New York, NY 10118
HCFA Project Officer:	Joanna K. Bandzwolek Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project developed computerized case report forms. The forms provide patient information to health care professionals to assist clinicians in making better informed and more cost-effective choices about the use of empiric antibiotic therapy on patients hospitalized with urinary tract infections.

Status: Phase I (development) was completed; however, Phase II (testing and data gathering) was not funded. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

93-054 Inventory of Emerging Health Care Technologies

Project No.:	HCFA-93-0746
Period:	July 1993–November 1993
Funding:	$ 25,000
Award:	Contract
Principal Investigator:	Jeffrey Lerner, Ph.D.
Awardee:	ECRI 5200 Butler Pike Plymouth Meeting, PA 19462
HCFA Project Officer:	Lawrence E. Kucken Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: The purpose of this project was to develop an inventory of emerging health care technologies. The project approach involved a literature review and an extensive search of health care technology data bases to develop a listing of technologies in their formative and late stages of emergence. The final inventory of emerging technologies involved refining this listing through a multidisciplinary expert review process. The inventory will be linked with the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS) to facilitate tracking of diffusion patterns.

Status: The final report has been accepted by HCFA and is being sent to the National Technical Information Service. The final report contains a matrix describing 92 emerging technologies. Approximately 50 percent of these technologies were found to have associated HCPCS codes.

93-041 **Medicaid Direct Purchase Vaccine Program: California** (Formerly, Medicaid Direct Purchase Vaccine Program)

Project No.:	11-P-90241/9
Period:	May 1993–May 1997
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Cathy Corgiat
Awardee:	California Department of Health Services 744 P Street Sacramento, CA 95814
HCFA Project Officer:	Alisa Adamo Division of Health Systems and Special Studies

Description: The Medicaid Direct Purchase Vaccine Program (MDPVP) is a statewide program, offered to all physicians participating in the Medicaid program. The program allows States to reimburse the manufacturers directly for vaccines. Vaccine manufacturers send each private physician treating children on Medicaid a shipment of vaccines on consignment to the State Medicaid program at no cost to the physician. As physicians inoculate Medicaid children with the vaccines, they bill Medicaid for the office visit but not for the cost of the vaccine itself. Instead, they note on the claim form the vaccine used; the Medicaid agency uses these claims data to notify the manufacturer of the number of replacement vaccines each physician requires and to reimburse the manufacturer for the used vaccines. The cost per vaccine under the MDPVP is the Centers for Disease Control and Prevention price plus a vaccine handling and distribution fee per vial of vaccine, not to exceed $3. Medicaid waivers were originally needed for the Medicaid agencies to directly reimburse the manufacturer for vaccines administered by enrolled health practitioners. The Omnibus Budget Reconciliation Act of 1993 amended the statute to permit Medicaid agencies to directly reimburse manufacturers for cost of the vaccine, but not for distribution of the vaccine; therefore, the waivers were amended to allow States to pay a vaccine handling and distribution fee.

Status: The California program is operational, however, California will not continue the program after October 1994.

93-004 **Medicaid Direct Purchase Vaccine Program: Virginia** (Formerly, Medicaid Direct Purchase Vaccine Program)

Project No.:	11-P-90173/3
Period:	November 1992–November 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Dee Holmes
Awardee:	Virginia Department of Medical Assistance Services 600 East Broad Street, Suite 1300 Richmond, VA 23219
HCFA Project Officer:	Alisa Adamo Division of Health Systems and Special Studies

Description: The Medicaid Direct Purchase Vaccine Program (MDPVP) is a statewide program, offered to all physicians participating in the Medicaid program. The program allows States to reimburse the manufacturers directly for vaccines. Vaccine manufacturers send each private physician treating children on Medicaid a shipment of vaccines on consignment to the State Medicaid program at no cost to the physician. As physicians inoculate Medicaid children with the vaccines, they bill Medicaid for the office visit but not for the cost of the vaccine itself. Instead, they note on the claim form the vaccine used; the Medicaid agency uses these claims data to notify the manufacturer of the number of replacement vaccines each physician requires and to reimburse the manufacturer for the used vaccines. The cost per vaccine under the MDPVP is the Centers for Disease Control and Prevention price plus a vaccine handling and distribution fee per vial of vaccine, not to exceed $3. Medicaid waivers were originally needed for the Medicaid agencies to directly reimburse the manufacturer for vaccines administered by enrolled health

practitioners. The Omnibus Budget Reconciliation Act of 1993 amended the statute to permit Medicaid agencies to directly reimburse manufacturers for cost of the vaccine, but not for distribution of the vaccine; therefore, the waivers were amended to allow States to pay a vaccine handling and distribution fee.

Status: The Virginia program is operational.

91-084 Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: Extending Medical Coverage to Certain Low-Income Families

Project No.:	11-C-99657/0
Period:	September 1991–August 1996
Funding:	$ 720,774
Award:	Cooperative Agreement
Principal Investigator:	Rochelle Salsman
Awardee:	State of Washington Department of Social and Health Studies 617 8th Avenue, SE. Olympia, WA 98504-5510
HCFA Project Officer:	James P. Hadley Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Section 4745 of the Omnibus Budget Reconciliation Act of 1990 mandated 3-year demonstration projects to test the effect of eliminating the categorical eligibility requirement and raising the financial eligibility limits to 150 percent of the Federal poverty level (FPL) on low-income individuals' access to, and cost of, health care. The Washington project, Health Access Spokane (HAS), is a collaborative effort between two State agencies, the Department of Social Services' Medical Assistance Administration and the Washington Basic Health Plan (BHP). The program covers those who are under 65 years of age, are not eligible for Medicaid, and have incomes below 200 percent of the FPL. In addition to providing coverage to the uninsured, this project tests the ability of the State to provide "seamless" coverage for individuals and families as they move from BHP, to demonstration, or to Medicaid status. During these transitions, coverage will be maintained and providers will remain the same, although there are differences in benefits available, depending on the program for which the individual is eligible. Individuals who live in Spokane are eligible to enroll in HAS if they are:

- current BHP members with family incomes below 150 percent of the FPL;
- current BHP members who are not enrolled in BHP but who are currently uninsured and have incomes below 150 percent of the FPL; or
- individuals who no longer qualify for Medicaid, but whose family income is below 150 percent of the FPL.

Services are delivered through a health maintenance organization (HMO) and a preferred provider organization (PPO). Enrollees are given a choice of plans. The organizations are paid a negotiated capitation rate, based on past experience with BHP enrollees and the additional benefits that will be offered in the demonstration HMO and PPO. The enrollment goal for the project is 2,950 members. Of this total, 1,200 are conversions from BHP.

Status: HAS began enrollment March 1, 1992. Service delivery began April 1, 1992. As of August 1, 1993, there were 1,498 enrollees (i.e., 1,200 BHP transfers and 298 previously uninsured enrollees). While the initial application included a "small employer" component, this portion of the project has been dropped to allow the State to focus more resources on individual enrollment of the previously uninsured population.

91-077 Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: Managed Care Demonstration Project for Low-Income Adults

Project No.:	11-C-99656/1
Period:	September 1991–September 1995
Funding:	$ 211,879
Award:	Cooperative Agreement
Principal Investigator:	Deborah Curtis
Awardee:	Maine Department of Human Services Bureau of Medical Services State House Station No. 11 Augusta, ME 04333
HCFA Project Officer:	Rose M. Hatten Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Section 4745 of the Omnibus Budget Reconciliation Act of 1990 requires a 3-year

demonstration to test the effect of eliminating the categorical eligibility requirement and raising the financial eligibility limits to 150 percent of the Federal poverty level (FPL) on low-income individuals' access to, and cost of, health care. Maine is one of three States serving as sites for this demonstration. The 3-year operational period will be preceded by a 9-month planning phase and followed by a 3-month close-out phase. The Maine project is a statewide project that builds on the existing Maine Health Program (MHP), which has been operational since October 1990, and extends Medicaid coverage to adults at or below 95 percent of the FPL. The demonstration differs from the current MHP in two ways: it expands eligibility for adults (20 years of age or over) from 95 percent of the FPL to 100 percent of the FPL and it makes primary care case management mandatory for those enrolled in the demonstration, except for those enrolled through employer-sponsored coverage. Enrollees whose employers offer them coverage are required to accept it if Maine finds it cost effective to "buy in."

Status: Waivers were approved on September 30, 1992. Current enrollment is 4,000. State fiscal crises have delayed the implementation of the primary care case management phase of the project. Maine has passed legislation mandating the privatization of the MHP by April 1, 1995, at which time the demonstration will end.

91-083 Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: South Carolina Health Access Plan

Project No.:	11-C-99653/4
Period:	September 1991–August 1996
Funding:	$ 500,000
Award:	Cooperative Agreement
Principal Investigator:	Brue Bondo
Awardee:	South Carolina State Health and Human Services Finance Commission P.O. Box 8206 Columbia, SC 29202-8206
HCFA Project Officer:	James P. Hadley Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Section 4745 of the Omnibus Budget Reconciliation Act of 1990 mandated 3-year demonstration projects to test the effect of eliminating the categorical eligibility requirement and raising the financial eligibility limits to 150 percent of the Federal poverty level (FPL) on low-income individuals' access to, and cost of, health care. In two South Carolina counties (Hoary and Marion), uninsured individuals below 150 percent of the FPL who are employed by small firms that have not offered health insurance coverage to their employees within the past 12 months will be offered coverage for themselves and their families. To be eligible for participation, employers must be located in 1 of the 2 demonstration counties, employ a minimum of 3 employees and no more than 100 employees, and not currently offer health insurance nor have done so within the past 12 months. Individuals employed are eligible if they have South Carolina residency; have total family incomes under 150 percent of the FPL; are under 65 years of age; and are not currently covered by Medicaid, Medicare, or other health insurance programs. All care is delivered through a primary care gatekeeper system. Physicians in the demonstration area who meet the credential requirement for participation in Medicaid are recruited to participate in the demonstration. Each participating physician is paid a monthly fee of $4 per enrollee to manage the care of each assigned patient. Demonstration recipients are able to choose a physician gatekeeper from a list of participating physicians for their health care, as well as an early and periodic screening, diagnosis, and treatment (EPSDT) provider for their children's health care (both could be the same person if the selected physician gatekeeper is also an EPSDT screener). The primary care physician gatekeeper is responsible for managing, coordinating, and controlling the member's/family's utilization of health care services through the direct provision of comprehensive primary care services (including providing for 24-hour 7-days-per-week access by telephone), authorizing specialist visits, and granting prior approval of any hospitalizations. Enrollment is projected to be approximately 1,300 participants during each year of the demonstration.

Status: Enrollment began March 1, 1992. Service delivery began April 1, 1992. As of August 1, 1994, approximately 150 employers and 1,000 subscribers were participating in the demonstration.

90-064 Medicaid Extension of Eligibility to Pregnant Women and Children Demonstration: Florida Medicaid Program and School Enrollment-Based Health Insurance

Project No.:	11-C-99638/4
Period:	September 1990–April 1995
Funding:	$ 274,020

Award: Cooperative Agreement
Principal Investigator: Jan Allgood
Awardee: Florida Agency for Health Care Administration
1317 Winewood Boulevard
Building 6, Room 271
Tallahassee, FL 32399-0700
HCFA Project Officer: Rose M. Hatten
Division of Health Services and Special Studies

Mandate: Omnibus Budget Reconciliation Act of 1989
(Public Law 101-239)

Description: As mandated by section 6407 of Public Law 101-239, this project extends Medicaid to children 6 through 18 years of age who are from families with incomes less than 185 percent of the Federal poverty level. Low-cost commercial health insurance will be marketed through the Florida school system by means of a nonprofit corporation (i.e., the Healthy Kids Corporation) established by the State to facilitate the provision of preventive health care services to children and to provide comprehensive coverage to children and their families. The insurance package has both a high (comprehensive) and a low (preventive and primary care only) option plan. The package is based on Medicaid reimbursement rates and provider networks consisting primarily of pediatricians and family practitioners who currently contract with Medicaid. Services are provided by the Florida Health Care Plan, a health maintenance organization under contract with the Healthy Kids Corporation.

Status: Enrollment began March 1, 1992, and is currently about 5,500. The State plans to expand the Healthy Kids program to 10 sites (without Federal grant funding) and to continue the program after the demonstration ends.

90-066 Medicaid Extension of Eligibility to Previously Ineligible Children Demonstration: Michigan Caring Program for Children

Project No.: 11-C-99633/5
Period: September 1990–August 1995
Funding: $ 115,000
Award: Cooperative Agreement
Principal Investigator: Champa Bhatia
Awardee: Michigan Department of Social Services
400 South Pine Street
Lansing, MI 48909
HCFA Project Officer: Paul J. Boben, Ph.D.
Division of Health Services and Special Studies

Mandate: Omnibus Budget Reconciliation Act of 1989
(Public Law 101-239)

Description: As mandated by section 6407 of Public Law 101-239, this program will extend Medicaid eligibility to children 6 through 18 years of age who are from families with incomes up to 185 percent of the Federal poverty level (FPL). The demonstration is a private and public partnership between the Michigan Medicaid program and Blue Cross and Blue Shield of Michigan. Blue Cross and Blue Shield will administer the plan, generate private contributions from community sources to help pay service costs, and reimburse providers on the basis of the standard Blue Cross and Blue Shield fee schedule. The mainstream benefit package will include most primary and preventive ambulatory care, but will exclude coverage of inpatient services.

Status: The waivers were approved as of September 1, 1992. Nearly 7,000 children are enrolled in the demonstration. Because of an additional $2 million in State funding, there is no longer a waiting list. The State's recent increase in Medicaid eligibility for children will soon begin to affect Caring Program's enrollment. As of July 1, 1994, all children 16 years of age or younger with family incomes less than or equal to 150 percent of FPL became eligible and will no longer be in the demonstration.

94-133 Medicaid-Managed Care and Avoidable Hospitalization

Project No.: 18-C-90369/3
Period: September 1994–September 1995
Funding: $ 177,312
Award: Cooperative Agreement
Principal Investigator: Anne Marie Gadomaski
Awardee: The University of Maryland at Baltimore
Department of Pediatrics/General Practrics
511 West Lombard Street
Baltimore, MD 21201
HCFA Project Officer: Paul J. Boben, Ph.D.
Division of Health Systems and Special Studies

Description: Since December 1991, the State of Maryland has required most categorically eligible Medicaid enrollees to participate in the Maryland Access to Care

(MAC) Program. Under MAC, each Medicaid enrollee chooses (or is assigned) a primary medical provider (PMP) who provides case management services and who acts as a gatekeeper for secondary and tertiary care. One objective of MAC is to improve access to primary and preventative care for the Medicaid population. In this evaluation, the awardee will seek to determine the effect of MAC on the number of avoidable pediatric hospitalizations. The analysis will be performed using hospital claims data from the Maryland Medical Assistance Program and the Maryland Health Services Cost Review Commission's hospital discharge data base (HDD).

Status: The cooperative agreement was approved on September 27, 1994. The first tasks will be to verify the reliability of the HDD diagnosis codes by comparing them to sampled medical records and to select specific *International Classification of Diseases, 9th Revision, Clinical Modification* codes for analysis.

94-007 Medicaid-Quality of Care: Primary Care, Episodic Care, and Expenditures for Selected Medical and Surgical Conditions in California, Georgia, and Michigan, 1991: Research File Development

Project No.:	500-94-0029
Period:	June 1994–December 1994
Funding:	$ 142,576
Award:	Contract
Principal Investigator:	Stephen H. Long, Ph.D.
Awardee:	The RAND Corporation 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Program Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: This project is part of the research effort by the Health Care Financing Administration to respond to the congressional mandate (Public Law 99-509) to measure the quality of care rendered to Medicaid patients. The awardee will link Medicaid medical records data files with eligibility, claims, and provider files. The cases are a representative sample of enrollees in the California, Georgia, and Michigan Medicaid programs who had emergency room visits and hospitalizations for pediatric asthma, hysterectomies, and complicated labor and deliveries (both mothers' and newborns' records) in calendar year 1991. These cases originally were selected for the Medicaid Quality of Care Study.

Status: The project is in the process of linking the files.

88-015 Medicaid Quality of Care Study

Project No.:	500-88-0044
Period:	June 1988–October 1994
Funding:	$ 5,874,673
Award:	Contract
Principal Investigator:	Nancy Merrick, M.D.
Awardee:	SysteMetrics, Inc. Santa Barbara Corporate Center 5425 Hollister Avenue, Suite 140 Santa Barbara, CA 93111
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Program Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: Under section 9432(c) of Public Law 99-509, the Department of Health and Human Services is required to report to Congress on a study that examines quality of care: the necessity, appropriateness, and effectiveness of selected medical treatments and surgical procedures for Medicaid patients. The study is assessing the variation that exists in the rate of performance of selected treatments and procedures on Medicaid beneficiaries for small areas within and among States. The study is determining underutilized, medically necessary treatments and procedures for which failure to furnish could have an adverse effect on health status and for which the rate of use by Medicaid beneficiaries is significantly less than the rate for comparable, age-adjusted populations.

Status: Phase I analysis has been completed. The report, "Patterns of Health Care Utilization in the Nonelderly Medicaid Population of Selected States," accession number PB93-184836, was delivered to Congress and is available from the National Technical Information Service. Findings from this report indicate that the overall observed rate of inpatient utilization in the Medicaid population was substantially higher than the rate expected based on non-Medicaid utilization patterns. The difference was more pronounced for medical conditions than for surgical conditions. Several conditions exhibited patterns of utilization that make them likely candidates for further study:

- Pediatric bronchitis and asthma was consistently the highest volume medical condition in the Medicaid population. The rate observed for this condition was notably higher than the rate expected based on non-Medicaid utilization patterns, and it exhibited high geographic variation within the Medicaid population.
- Hysterectomy was consistently one of the highest volume inpatient surgeries in the Medicaid population and in some cases exhibited notable variation from one geographic area to another.
- Pregnancy-related conditions by far were the major source of inpatient admission in the population under 65 years of age in Medicaid. The volume alone, as well as the higher rate of an admission for post-partum conditions in Medicaid, points to the need for further inquiry in this area.

The Phase II study is under way and involves reviewing medical records of patients who were hospitalized for three conditions important to the Medicaid population: pediatric asthma, hysterectomy, and complicated delivery. This contract was completed after the abstraction of the medical records. A separate contract was awarded to conduct the analysis and write the report.

88-016 Medical Assistance Facility Demonstration Project

Project No.:	95-C-99292/8
Period:	June 1988–July 1997
Funding:	$ 778,357
Award:	Cooperative Agreement
Principal Investigator:	Keith McCarty
Awardee:	Montana Hospital Research and Education Foundation P.O. Box 5119 Helena, MT 59604
HCFA Project Officer:	Siddhartha Mazumdar, Ph.D. Division of Hospital Experimentation
Mandates:	Section 4008(i)(1) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) (Amended by Section 13507 of the Omnibus Budget Reconciliation Act of 1993, Public Law 103-66)

Description: The Montana Hospital Research and Education Foundation (MHREF) is conducting a demonstration of the utility and desirability of medical assistance facilities (MAF), limited-service hospital models located in remote rural frontier areas. The MAF is a new category of licensure in Montana for health care facilities providing emergency, outpatient, and low-intensity acute care services to short-term inpatients. MAFs are intended to maintain accessibility to basic acute and emergency care services and provide limited inpatient care for no longer than 96 hours. These facilities are located in counties with fewer than six residents per square mile or in areas more than 35 miles from the nearest hospital. MAFs maintain agreements with larger full-service hospitals and other providers to ensure the availability of a full network of services. In enacting section 4008(i)(1) of Public Law 101-508, Congress provided the authority to implement the demonstration. Section 13507 of the Omnibus Budget Reconciliation Act of 1993 amends this section of the law and extends the demonstration through July 1997. This project consists of two phases. Phase I (planning and development) addressed technical issues, including payment formula, services covered, and design of a project evaluation. Phase II is the implementation, operation, and evaluation of the demonstration.

Status: The MAF demonstration is the first time that limited-service hospitals have received Health Care Financing Administration (HCFA) certification to be reimbursed for the provision of inpatient services to Medicare beneficiaries. The project has served as a prototype in the development of the Essential Access Community Hospital program. HCFA and MHREF have worked to develop the MAF concept by defining service, staffing, and equipment capabilities at each of the demonstration sites. In addition, utilization and cost projections have been prepared to estimate the financial impact of the project on the facilities and on the Medicare program. HCFA and MHREF have developed conditions of participation and certification requirements, quality assurance and utilization review procedures, and payment systems for MAFs. The facilities are subject to rigorous utilization and quality review by the peer review organization (PRO), including preadmission and concurrent review of all inpatients, in addition to the PRO's normal retrospective review procedures. MAFs are reimbursed for the provision of all services on a reasonable cost basis by the Medicare and Medicaid programs (Blue Cross and Blue Shield of Montana also participates in the demonstration by reimbursing MAFs on a reasonable cost basis). During fiscal year 1991, the developmental aspects of the demonstration were completed and Phase II (demonstration) began. Six MAFs are operating currently in Montana.

89-032 Medicare Catastrophic Coverage Act Evaluation: Beneficiary and Program Impacts

Project No.:	500-89-0063
Period:	September 1989–December 1994

Funding:	$ 2,666,951
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Program Studies

Description: The contract comprises a series of research projects related to the analysis of Medicare benefit changes and Medicaid beneficiary expansions introduced by the Medicare Catastrophic Coverage Act (MCCA) of 1988. The analyses focus on the Medicare benefit changes in skilled nursing care and hospice care. The analyses also address the MCCA-introduced payment of Part A and Part B premiums, and the deductibles and copayments for low-income qualified Medicare beneficiaries by State Medicaid programs. Data on usage in a private nursing home chain are studied, and nursing home episodes for Medicare beneficiaries through a linking of Part A and Part B bills are identified. Post-hospital use is studied through two tracer conditions—stroke and hip fracture. The Medicaid analyses primarily focus on the effects of the expansions for pregnant women and their infants. Analyses of birth and death records are conducted on national vital statistics data. Missouri birth and infant death data are linked with Medicaid eligibility and utilization data and analyzed for changes over time in Medicaid enrollment of pregnant women and the birth outcomes of their infants. Analysis of a year of infant health care utilization includes data from birth certificates and mothers' Medicaid eligibility. A trend analysis of Massachusetts hospital discharge data focuses on shifts in Medicaid usage, lengths of stay, severity of birth outcomes, and Neonatal Intensive Care Unit use before and after the MCCA legislation.

Status: Work on the contract was suspended until November 1990, pending the revision of the contract commensurate with the recision by Congress of the Medicare aspects of the MCCA. Work is under way on several of the Medicare and Medicaid analyses, and work on the final report is commencing. Three reports are available: Coulam, R.F.: "Analysis of Massachusetts Births, 1984–1990: Evaluation of Medicare Catastrophic Coverage Act," accession number PB93-112696, from the National Technical Information Service; Gavin, N.I.: "Review and Synthesis of the Literature on Financial Barriers to Health Care Services for Children," February 21, 1992; and Coulam, F.R.: "Literature Review: Prenatal Care and the Effects of Liberalizing Medicaid Eligibility" (draft), April 4, 1991, from the project officer. The Coulam report analyses births from Massachusetts hospital discharge data for years 1984 through 1990. A birth-outcome grouping based on the *International Classification of Diseases, 9th Revision, Clinical Modification* codes is used, along with payer source, to show that the number of Medicaid-enrolled women delivering babies has increased over time.

89-028 Medicare Catastrophic Coverage Act Evaluation: Impacts on Industry

Project No.:	500-89-0064
Period:	September 1989–September 1994
Funding:	$ 993,199
Award:	Contract
Principal Investigator:	Marilyn Moon, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Program Studies

Description: The contract comprises a series of research projects assessing the effects of the benefit changes introduced by the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) on relevant health care providers, specifically hospitals, nursing homes, and home health agencies.

Status: Preliminary analyses indicate that increased Medicaid nursing home payments are paid for patients who were previously self-pay. While overall bad debt in hospitals is increasing, the bad debt for hospitals with the largest maternity load has decreased somewhat. No offset appears to occur between nursing home and home health utilization. Final analyses are under way, and the final report is being prepared. Papers include:

- Dubay, L.C., Norton, S.A., and Moon, M.: Hospital Uncompensated Care Burdens: National Trends and the Impact of the Medicaid Expansions. Washington, D.C. November 1993.
- Kenney, G.M., and Moon, M.: The Relationship Between Medicare Home Health and SNF Use After Implementation of the Medicare Catastrophic Coverage Act. Washington, D.C. April 1994.
- Kenney, G.M., and Moon, M.: Supply Changes in Medicare Home Health Care in the 1980s. October 1993.
- Kenney, G.M., and Moon, M.: Descriptive Analyses of Changes in Medicare SNF and Home Health Use. Washington, D.C. The Urban Institute, August 1992.

- Liu, K., Taghavi, L., and Cornelius, E.: Changes in Medicaid Nursing Home Beds and Residents. October 1992.

IM-009 Medicare Cohort Study: Utilization and Costs for Aged and Disabled Decedents in 1992, 1974–92

Funding: Intramural
HCFA Project Director: Alma B. McMillan, Division of Beneficiary Studies

Description: Using data from the 5-percent Continuous Medicare History Sample file, the Medicare experience from 1974 to 1992 will be studied. A major objective of this project is to gain additional understanding of factors relating to total program payments over the lifetime of beneficiaries. The most common diagnoses and procedures requiring hospitalization also will be analyzed.

Status: This project is in the early planning phase.

IM-023 Medicare Disabled Population: Utilization and Costs, 1974–92

Funding: Intramural
HCFA Project Director: Alma B. McMillan, Division of Beneficiary Studies

Description: Using data from the Continuous Medicare History Sample and the Medicare provider analysis and review files, this study will examine trends in enrollment, expenditures, and hospitalizations by diagnostic group for Medicare disabled beneficiaries and those 65-69 years of age from 1974 through 1992. Utilization for disabled enrollees will be compared with that for enrollees 65-69 years of age. This analysis will provide information on the impact that disabled Medicare enrollees have on program outlays.

Status: This project is in its early data development phase. The Bureau of Data Management and Strategy has produced some preliminary tabulations.

IM-028 Model to Predict Adverse Drug Reactions Caused by Thrombolytic Agents

Funding: Intramural
HCFA Project Director: Leslye Fitterman, Division of Beneficiary Studies

Description: This study is an epidemiologic evaluation of hospitalizations of elderly Medicare beneficiaries caused by adverse drug reactions (ADR) to thrombolytic agents. Claims data for all services reimbursed by Medicare will be analyzed. Person-level analytical files are being constructed from three Medicare data systems: the Medicare provider analysis and review file, the enrollment data base, and the National Claims History file. The study population is comprised of two groups of beneficiaries: all persons hospitalized in 1992 with a discharge diagnosis indicating an anticoagulant ADR and a 20-percent sample of all persons undergoing routine laboratory monitoring while taking anticoagulants. The study has three broad objectives:

- Determine the rate of admissions to hospitals for treatment of an ADR to anticoagulant therapy.
- Analyze the relationship between the rate of ADR hospitalizations and the risk factors associated with an ADR caused by anticoagulant therapy.
- Develop a model for predicting ADRs caused by anticoagulant therapy.

Status: Data analysis files are being constructed for the two study populations. Demographic and programmatic criteria for inclusion were established. The criteria for inclusion are: persons 65 years of age or older; race designated as black or white; State of residence other than Puerto Rico, Virgin Islands, or unknown; persons not enrolled in a health maintenance organization or a managed care plan; and persons enrolled in Part A and Part B of the Medicare program. The application for the inclusion criteria to the two samples has been completed. In 1992, there were 9,240 elderly beneficiaries hospitalized for treatment of an ADR to anticoagulant therapy. The 20-percent sample of all persons undergoing routine laboratory monitoring while taking anticoagulants in 1992 is comprised of 105,565 persons.

93-052 Monitoring Physician Supply Patterns

Project No.: HCFA-93-0731
Period: July 1993–September 1993
Funding: $ 19,000
Award: Contract
Principal Investigator: Julie A. Schoenman, Ph.D.
Awardee: The People-to-People Health Foundation, Inc.
Center for Health Affairs
7500 Old Georgetown Road, Suite 600
Bethesda, MD 20814-6133
HCFA Project Officer: Lawrence E. Kucken, Division of Beneficiary Studies

Mandate: Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: The purpose of this project was to develop an analytic file and a set of tables describing physician-to-Medicare population ratios for the period 1984–92. These ratios were derived from the Health Resources and Services Administration's area resource file and the Health Care Financing Administration's (HCFA) Medicare denominator file and were presented in terms of overall medical and surgical physician groupings. Tables were categorized according to census regions and urban or rural areas describing the baseline period prior to the implementation of the Medicare physician fee schedule.

Status: The final report has been accepted by HCFA and is being sent to the National Technical Information Service. As found in prior analyses, the report shows higher physician concentrations in the Northeast and West regions compared to the rest of the Nation. Higher relative concentrations in metropolitan areas also are shown.

IM-010 Monitoring Utilization of and Access to Services for Medicare Beneficiaries under Physician Payment Reform

Funding:	Intramural
HCFA Project Director:	Ann Meadow, Sc.D. Division of Payment and Economic Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: The Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1989, specified a new payment system for Medicare physicians' services. This intramural project is one of several analyzing effects of the new system on access to care. The work being performed in the Division of Payment and Economic Studies (DPES) focuses on access impacts of the Medicare fee schedule (MFS) from the perspective of the physician. Although population-based utilization data can measure access as an outcome, such information does not explain the process by which physicians respond to policy change and thereby influence access. This project analyzed all available Medicare Part B claims from a panel of physicians identified by their Unique Physician Identification Number (UPIN). The panel comprised physicians from 18 selected States who had any allowed charges in both 1991 and 1992, and who had been assigned a UPIN by January 1, 1991. DPES examined the 7,361 physicians' 1-year change in a series of access-related measures, including caseload (i.e., number of beneficiaries treated in a year), continuity in performing specific procedures, total allowed charges, and assigned charges as a proportion of allowed charges.

Status: The initial report of findings was included in the 1994 Annual Report to Congress "Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access." Direct measurement of caseload change suggested that the mean number of patients grew in 12 of the 18 State samples, but the average addition to caseload was, in most instances, modest. However, after adjusting for the loss of "recorded" patients that occurred in 1992 (because of the bundling of electrocardiogram payments into visit fees), we estimated that the mean caseload increased in 17 States, 11 significantly. The percent increase ranged between 4 and 13 percent. DPES observed no relationship between the changes in caseload and the statewide average price change forecasted by the Health Care Financing Administration in 1991. Of 45 surgical and other procedural services, DPES observed statistically significant declines in the number of physicians performing ambulatory inguinal hernia repair and hip fracture repair. In addition, fewer physicians performed miscellaneous minor procedures, but this appears to have resulted from coding system changes in 1991 and 1992. More physicians performed cataract operations, musculoskeletal ambulatory procedures, and laparoscopic cholecystectomy. Average Medicare-allowed charge revenues were stable in a majority of the State samples; however, significant increases occurred in several States expecting average price changes of 0 percent to -3 percent. For surgeons, allowed charges declined 3 percent, or about $2,900 per physician. Relative to their 1991 reimbursements, more physicians experienced sizable gains than sustained sizable losses. Physicians accepted assignment on a larger proportion of their allowed charges in all the States. All racial groups experienced a favorable trend in assignment rates. Overall, the analysis suggested that access may have changed for the better with the advent of the MFS. Physicians generally took on more Medicare patients at the same time that they eased financial barriers by increasingly accepting the Medicare-determined fee. The general stability of performance rates for procedures suggests that physicians did not cease providing services whose price was more likely to decline. As expected, substantial reductions in total Medicare reimbursements affected some individual physicians, but this was not widespread. The next phase of the study will track a sample of physicians for 3 years and will compare impacts in rural versus urban areas.

94-073 **Multistate Analysis of Utilization, Expenditures, and Access to Care for Persons with Acquired Immunodeficiency Syndrome**

Project No.:	500-92-0022DO04
Period:	September 1994–September 1996
Funding:	$ 490,114
Award:	Delivery Order in Master Contract
Principal Investigator:	Craig Thornton, Ph.D.
Awardee:	The University of Minnesota (See page 214)
HCFA Project Officers:	Lawrence E. Kucken and Michael Kendix, Ph.D. Division of Beneficiary Studies

Description: The objective of the project is to conduct a study focusing on persons with acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV)-related diseases who are covered by a variety of financing mechanisms. In particular, the project will conduct a statistical investigation and will examine trends in enrollment, service utilization, and expenditure patterns of Medicare, Medicaid, and private insurance patients between 1990 and 1992. It will compare programs and assess differences in access to care. The project will provide more expansive and current data on utilization and expenditures related to AIDS and HIV health services.

Status: This project is in the early developmental stage.

93-029 **National Ambulatory Electrocardiographic Quality Assurance Program**

Project Nos.:	97-P-08013/2-01 (Phase I) 97-P-08013/2-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 35,514 (Phase I) $ 100,364 (Phase II)
Award:	Grant
Principal Investigator:	John J. DeCamilla, Jr.
Awardee:	Scientific Associates 1349 South Street Rochester, NY 14620
HCFA Project Officer:	Michael J. Baier Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The goal of this project is to determine the feasibility of developing a national ambulatory electrocardiographic quality assurance program for physicians and for staffs of independent laboratories, clinics, and hospitals, all of whom provide these procedures.

Status: This project is in Phase II (testing and data gathering). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-041 **New Jersey Welfare Reform: Family Development Program**

Project No.:	11-W-00016/2
Period:	July 1992–September 1997
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	William Waldman
Awardee:	New Jersey Department of Human Services CN 700 Trenton, NJ 08625-0700
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Health Care Financing Administration and the Administration for Children and Families to:

- Require that recipients of Aid to Families with Dependent Children (AFDC) in New Jersey participate in vocational assessment and counseling, if their youngest child is over 2 years of age, and impose financial penalties for nonparticipation.
- Allow children to remain AFDC eligible if the AFDC mother marries someone other than the natural father and the family income is below 150 percent of the Federal poverty level (FPL), but give no AFDC payment increase for any child born while a family is on welfare.
- Expand education and employment activities, and disregard more of initial earnings, while also allowing two-parent families to have the same earnings as single-parent families before losing AFDC eligibility.

- Allow these families who work their way off welfare to have a 24-month Medicaid extension, with no income limit during the extension period. (Current law provides a 6-month Medicaid extension, regardless of income, with an additional 6 months contingent upon earnings below 185 percent of the FPL.)

Status: The waivers for this demonstration have been implemented. Approximately 20 percent of the AFDC population is participating in the Family Development Program.

93-017 Nursing Facility Management Software to Monitor Quality of Care

Project Nos.:	97-P-08003/6-01 (Phase I) 97-P-08003/6-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 34,760 (Phase I) $ 99,640 (Phase II)
Award:	Grant
Principal Investigator:	Robert C. Godbout, Ph.D.
Awardee:	Austin Data Management Associates P.O. Box 4358 Austin, TX 78765
HCFA Project Officer:	Michael J. Baier Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The goal of this project is to design personal computer software and training materials that would make quality of care information accessible and usable to nursing facility managers and others. The software would analyze resident outcomes, service patterns, and staffing to assist the user in monitoring the quality of care in nursing facilities and to suggest management decisions for improving quality.

Status: This project is in Phase II (testing and data gathering). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

IM-011 Organ Transplant Analysis

Funding:	Intramural
HCFA Project Director:	Lawrence E. Kucken Division of Beneficiary Studies

Description: This study analyzes the costs, utilization, and survival characteristics of Medicare patients having undergone heart, liver, and lung transplants during the period of 1987–92. The study focuses on the hospitalization in which the transplant was performed (using the Medicare provider analysis and review file), linked with pre- and post-hospitalization data from the Medicare Automated Retrieval System and the National Claims History File. Descriptive analyses will focus on demographic characteristics of transplant recipients. Transplant failure rates also are calculated. The linked record will be used to estimate total Part A and Part B utilization and Medicare payments associated with these transplant procedures.

Status: A draft manuscript describing transplant patient characteristics and associated hospital costs has been prepared and is under review at the Health Care Financing Administration.

IM-012 Patterns and Outcomes of Cancer Care in the Medicare Population

Funding:	Intramural
Project Directors:	Gerald F. Riley, James D. Lubitz, and Renee Mentnech Division of Beneficiary Studies

Description: More than one-half of all cancer patients have Medicare coverage. A data base that links Medicare data with cancer registry data collected through the National Cancer Institute's surveillance, epidemiology, and end results (SEER) program has been created. The SEER program covers approximately 10 percent of the U.S. population. This data base contains information on the anatomic site of the primary cancer, histology, stage of the disease at diagnosis, and date of diagnosis for each new case of cancer in the program's geographic areas. Linking SEER and Medicare data will provide opportunities for research on issues of access to medical care, Medicare costs incurred by cancer patients, and patterns of medical care received by cancer patients diagnosed with various sites, stages, and histologies of cancer. Some specific questions to be addressed are:

- What are overall Medicare costs, by type and stage of cancer?
- What are the Medicare costs that are specifically related to cancer care?

- What comorbidities are associated with cancer and how do they influence Medicare use and cost?
- What is the mix of care (on a per person basis) among community hospitals, teaching hospitals, and cancer centers?
- What are the institutional factors that influence the type of inpatient hospital care received by cancer patients?

Status: SEER and Medicare data have been linked for all nine registries for all cases diagnosed from 1973 to 1989. The following article has been published describing the linked data base: Potosky, A.L., Riley, G.F., Lubitz, J.D., *et al.*: Potential for cancer-related health services research using a linked Medicare tumor-requesting data base. *Medical Care*. 31:732-747, 1993. Researchers are conducting initial studies on total Medicare costs incurred by cancer patients, as well as costs of cancer care, and will present costs by stage at diagnosis, demographic variables, and geographic area. A study comparing stage of cancer at diagnoses between health maintenance organization members and beneficiaries in fee-for-service was published in the article, "Stage of Cancer in Diagnosis for Medicare HMO and Fee-for-Service Enrollees," by Riley, G.F., Potosky, A.L., Lubitz, J.D., Brown, M.L. in the *American Journal of Public Health*, 84(10):1598–1604, October 1994. Studies related to the patterns and outcomes of care for colorectal, prostate, and lung cancer are in the developmental phase.

92-057 Payment of Pharmacists for Cognitive Services

Project No.:	11-C-90229/0
Period:	September 1992–March 1995
Funding:	$ 721,588
Award:	Cooperative Agreement
Principal Investigator:	Dale Christensen, Ph.D.
Awardee:	State of Washington Department of Social and Health Services 623 8th Avenue, SE. Olympia, WA 98504-5510
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this demonstration project is to test the effect of paying pharmacists for cognitive services. The demonstration design includes 100 treatment and 100 control pharmacies that have volunteered to participate. In addition, a comparison group of 100 nonvolunteer pharmacies will be recruited. Washington State will reimburse pharmacists assigned to the treatment group for providing cognitive services that can be linked to a prescription problem and that involve a change in prescription, a decision not to dispense, or an extension of patient counseling. Pharmacists will receive $4 for an intervention of 6 minutes or less and $6 for an intervention of more than 6 minutes.

Status: This project was implemented on February 1, 1994.

94-014 Physician Supply Analysis under the Medicare Fee Schedule: 1994 Update

Project No.:	HCFA-94-1163
Period:	September 1994-December 1994
Funding:	$ 20,000
Award:	Contract
Principal Investigator:	Julie A. Schoenman, Ph.D.
Awardee:	The People-to-People Health Foundation, Inc. Center for Health Affairs 7500 Old Georgetown Road, Suite 600 Bethesda, MD 20814-6133
HCFA Project Officer:	Lawrence E. Kucken Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: The purpose of this project is to provide a set of tables containing physician supply (physician-to-Medicare population ratios) data for the period January 1984 through January 1993. These data will be derived from the Health Resources and Services Administration's area resource file and the Health Care Financing Administration's denominator file. These data will be used to measure possible early effects of Medicare's physician fee schedule on access to physician services as measured by geographic concentration patterns.

Status: This study is in the early developmental stage.

93-025 Portable Automatic Lens Focusing System for the Visually Impaired

Project No.:	97-P-08044/3
Period:	February 1993–January 1994
Funding:	$ 34,998
Award:	Grant

Principal Investigator:	Dr. Beth Schrope
Awardee:	Reshet, Inc. 314 North 32nd Street Philadelphia, PA 19104-2504
HCFA Project Officer:	Carl Hackerman Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project tested the feasibility of producing a portable, lightweight, automatic focusing (autofocus) system for telescopic lenses.

Status: Phase I (development) was completed; however, Phase II (product development) was not funded. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

90-063 Post-Hospitalization Outcomes Studies

Project No.:	500-90-0046
Period:	September 1990–March 1995 September 1990–September 1991 (Design Phase) July 1992–September 1996 (Implementation Phase)
Funding:	$ 1,282,667 $ 152,286 (Design Phase) $ 1,130,381 (Implementation Phase)
Award:	Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	The University of Minnesota School of Public Health Institute for Health Services Research D-351 Mayo Memorial Building 420 Delaware Street, SE., Box 197 Minneapolis, MN 55455-0392
HCFA Project Officer:	Joan L. Warren, Ph.D. Division of Beneficiary Studies

Description: The Post-Hospitalization Outcomes Studies (PHOS), in collaboration with the Agency for Health Care Policy and Research, under an interagency agreement, will assess the long-term outcomes for elderly Medicare beneficiaries undergoing cholecystectomy and elective total hip replacement. Findings from these studies will help:

- Determine the types and rates of beneficial outcomes and complications in the post-hospital period.
- Determine the relationship between particular types or combinations of service and good/poor outcomes.
- Determine the impact of hospitalization-specific procedures on the progression of illness and health-functional status.
- Determine if patient satisfaction with hospitalization is related to long-term outcomes.
- Identify population subgroups or specific patient characteristics that are associated with high rates of post-hospitalization complications.

Status: A pretest was conducted between October 1992 and June 1993. The full study will begin in October 1994. Data for PHOS were obtained from telephone interviews with Medicare beneficiaries who have been recently hospitalized for the selected procedures, from medical records, and from Medicare claims data. Patients will be contacted at 2 weeks, 6 months, and 12 months following discharge. Final data from the two conditions will be available in early 1996.

93-019 Preliminary Study of Hand-Held Data Collection Systems for Home Health Care Quality Management

Project No.:	97-P-08073/1
Period:	February 1993–January 1994
Funding:	$ 34,578
Award:	Grant
Principal Investigator:	Bruce W. Webb, Ed.D.
Awardee:	Dolley, Keniston, & Webb 1021 Burnham Road, Suite 727 Gorham, ME 04038
HCFA Project Officer:	Michael J. Baier Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project will test the feasibility of using hand-held data-collection instruments for home health care patient management. The potential outcome is a system of data collection that will be easy to use, be consistent, and provide agencies, regulatory bodies, and reimbursement parties with useful measures of performance and quality.

Status: Phase I (development) was completed; however, Phase II (product development) was not funded. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-029 Program of Preconceptional Intervention for Women at Risk for Low-Birth-Weight Infants

Project No.:	11-C-90154/4
Period:	February 1992–May 1998
Funding:	$ 917,324
Award:	Cooperative Agreement
Principal Investigator:	Marshall E. Kelley
Awardee:	Florida Agency for Health Care Administration 1317 Winewood Boulevard Building 5, Room 422 Tallahassee, FL 32399-0700
HCFA Project Officer:	Rosana Hernandez-Albertini Division of Health Systems and Special Studies

Description: The project is designed to demonstrate and evaluate an innovative preconceptional intervention program utilizing Resource Mothers who, during home visits, guide high-risk clients through risk-reduction activities, stressing healthy spacing of pregnancies. The evaluation will determine the program's effect on patient access and utilization of health care, participation in indicated community services, adaptation of health behaviors, and pregnancy outcomes.

Status: This project received Federal waivers to provide operation of services from June 1994 through May 1998.

93-030 Prove the Feasibility of a Very High-Efficiency Pumping Mechanism for a Low-Cost, Lightweight, High-Quality Intravenous Pump

Project No.:	97-P-08019/1
Period:	February 1993–January 1995
Funding:	$ 98,079
Award:	Grant
Principal Investigator:	Charles Khuen
Awardee:	IV Systems, Inc. 131 Forest Street Winchester, MA 01890
HCFA Project Officer:	Carl S. Hackerman Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project will build and test a high-efficiency pumping mechanism for a low-cost, high-quality intravenous pump.

Status: This project has completed Phase I (development). A final report has been received. The project is in Phase II (build and test). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-051 Quality of Care among Cohorts of Medicaid Children

Project No.:	500-92-0058
Period:	September 1992–June 1994
Funding:	$ 59,149
Award:	Contract
Principal Investigator:	Jay H. Glasser, Ph.D.
Awardee:	Systems Management Associates 5427 Valkeith Houston, TX 77096
HCFA Project Officer:	Penelope L. Pine Division of Program Studies

Description: The purposes of this project are to provide the Health Care Financing Administration with information on how differences between continuous and discontinuous Medicaid enrollment impact utilization and expenditure patterns for clinical conditions, and whether there are access and quality of care issues for cohorts of young Medicaid children. Emphasis is to be placed on the application of longitudinal methodologies and analysis of complex factors that determine health resource utilization, cost, and continuity of care within selected cohorts of children in California, Georgia, and Michigan.

Status: The principal investigator is in the process of writing the final report.

94-006 Quality of Care: Medicaid and Other Populations

Project No.:	500-94-0017
Period:	June 1994–June 1995

Funding:	$ 439,857
Award:	Contract
Principal Investigator:	Nancy Merrick, M.D.
Awardee:	SysteMetrics, Inc. Santa Barbara Corporate Center 5425 Hollister Avenue, Suite 140 Santa Barbara, CA 93111
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Program Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The purpose of the project is to analyze a medical records data set to assess medical necessity, appropriateness, and effectiveness (outcomes) of selected treatments and procedures in the Medicaid and privately insured populations in response to the congressional mandate (Public Law 99-509). The data base includes records of emergency room and inpatient care for pediatric asthma, inpatient hysterectomy, and complicated labor and delivery (which includes mothers' and their newborns' records). A secondary data analysis is to be conducted of the outcomes of a sample of Medicaid pediatric asthma patients enrolled in managed care plans compared to a sample receiving care through regular fee-for-service arrangements. This contract builds on the Health Care Financing Administration's quality of care research agenda in the context of health care reform.

Status: The analytic plan is being developed.

IM-026 Racial Disparities in Coronary Artery Bypass Graft Surgery and Percutaneous Transluminal Coronary Angioplasty Use: A Socioeconomic Effect?

Funding:	Intramural
HCFA Project Director:	Renee Mentnech Division of Beneficiary Studies

Description: Numerous studies have documented large racial differences in the rates of use of coronary care procedures. To determine the extent to which these findings reflect differences in the levels of insurance coverage and socioeconomic status, this study examines the rates of coronary artery bypass graft (CABG) surgery and percutaneous transluminal coronary angioplasty (PTCA) use in the population covered by both Medicare and Medicaid (for which Medicaid eligibility is based on income).

Status: The Medicare enrollment files for 1991 and 1992 were used to identify the study population. The Medicare provider analysis and review files for 1991 and 1992 were used to determine the number of CABGs and PTCAs. After calculating use rates by race and gender, the rates were adjusted for prevalence of coronary artery disease. A paper is being prepared for publication.

91-059 Rates of Inpatient and Outpatient Shunt Procedures for End Stage Renal Disease Beneficiaries

Project No.:	99-C-98489/9
Period:	August 1991–July 1993
Funding:	$ 103,906
Award:	Cooperative Agreement
Principal Investigator:	Joel D. Kallich, Ph.D.
Awardee:	The RAND Corporation (See page 211)
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies

Description: The most frequent cause of hospitalizations among end stage renal disease beneficiaries is the insertion, repair, or replacement of the vascular access device, or the shunt. The purpose of this study is to examine physician services for shunt procedures for their dialysis patients and to examine cost differences between inpatient and outpatient settings.

Status: The final report, "Patterns of Inpatient Physician Services for End-Stage Renal Disease Beneficiaries" by Joel Kallich, John Adams, and S.A. Rahman will be sent to the National Technical Information Service. Approximately 85 percent of shunt creations and 75 percent of shunt complications are treated in an inpatient setting. Black persons are over 50 percent more likely to have a shunt creation or complication. Diabetics have a relative risk of shunt creation 33 percent higher than for "other" causes of renal failure, presumably caused by the clinical complications of diabetes. The shunt creation rate was 36 per 100 dialysis beneficiaries during 1990. Total allowed charges for physicians in 1990 were $48.9 million. Inpatient covered charges for hospitalization, primarily for a shunt-related procedure, were $272.8 million.

IM-024 Rehabilitation Facilities and Units: Utilization, Cost, and Payment

Funding:	Intramural
HCFA Project Director:	William Buczko, Ph.D. Division of Payment and Economic Studies

Description: This project will examine utilization and financial trends in the Medicare prospective payment system (PPS)-excluded freestanding facilities and units in inpatient hospitals. Issues related to the creation of a PPS for inpatient rehabilitation providers also will be examined.

Status: This project has begun examination of the Medicare provider analysis and review and Hospital Cost Report Information System data to develop a description of the utilization and cost trends in PPS-excluded rehabilitation facilities and units. This project also will examine issues related to the development of a system for measuring case-mix variation in inpatient rehabilitation populations and other issues related to the creation of a PPS for reimbursement of Medicare inpatient rehabilitation care.

IM-013 Rehospitalization Study

Funding:	Intramural
HCFA Project Director:	Gerald F. Riley Division of Beneficiary Studies

Description: In December 1987, the Health Care Financing Administration (HCFA) released hospital-specific mortality data to the public. The reason for releasing these data was to serve the public interest in quality of health care by providing information that hospitals, physicians, and consumers could use to help make decisions about selection of health care providers. HCFA is interested in releasing additional data to serve the same purpose. This study is designed to develop alternative outcomes (to mortality) for eight surgical procedures that could be useful in public releases as quality of care indicators. Primarily, this project is looking at the utility of rehospitalization rates as quality of care indicators. This project is designed to:

- Develop outcome measures using the 100-percent Medicare provider analysis and review file. Rehospitalizations will be examined as well as adverse events occurring during the surgical stay.
- Convene panels of physicians to review data and make suggestions about identifying poor outcomes that could reflect quality of care problems.
- Develop rates of categories of adverse outcomes by demographic characteristics and by metropolitan statistical areas and rural areas within States.

Status: Three specialty panels of physicians were convened to identify adverse outcomes occurring during the initial stay or associated with a readmission. Rates of adverse outcomes were subsequently developed for the initial stay and for readmissions. The results of the study were published in June 1990 as a special report entitled "Rehospitalization by Geographic Area for Aged Medicare Beneficiaries: Selected Procedures, 1986–87." Copies of the report can be obtained from the National Technical Information Service (NTIS), accession number PB90-258542. A personal computer diskette with data contained in the report also is available from NTIS, accession number PB91-507418. An article, "Medicare Beneficiaries: Adverse Outcomes after Hospitalization for Eight Procedures," by Gerald Riley, James Lubitz, Marian Gornick, *et al.* was published in *Medical Care* 31(9):921–949, 1993. An article, "Rehospitalization after Coronary Revascularization Among Medicare Beneficiaries" (Vol. 72), by James Lubitz, Marian Gornick, Renee Mentnech, *et al.* appeared on pages 26–30 of the July 1, 1993, issue of *The American Journal of Cardiology.*

90-061 Review of the First Year of Medicare Coverage of Erythropoietin

Project No.:	500-90-0051
Period:	September 1990–December 1993
Funding:	$ 401,099
Award:	Contract
Principal Investigator:	Neil Powe, M.D.
Awardee:	The Johns Hopkins University Program for Medical Technology and Practice Assessment 1830 East Monument Street, Room 8061 Baltimore, MD 21205
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The Health Care Financing Administration (HCFA) began covering human recombinant erythropoietin (EPO) for end stage renal disease dialysis beneficiaries in July 1989. This study examined access to care, practice patterns, costs, and outcomes of EPO following its coverage by HCFA.

Status: Six peer-reviewed papers have been published as well as several abstracts and presentations. Principal findings are that EPO was accepted rapidly by dialysis providers and patients. Dosages were well below amounts used in clinical trials and the resultant increases in hematocrit also were below expectations. For-profit and freestanding dialysis facilities tended to provide EPO to a higher proportion of their patients, but to prescribe lower average doses. EPO appears to have little impact on total

inpatient services, but there are some small changes in specific-cause hospitalizations. The final report, "Review of the First Year of Medicare Coverage of EPO," by Neil R. Powe, Gregory De Lissovoy, and Robert I. Griffiths, *et al.*, is being sent to the National Technical Information Service.

89-029 **Rural Health Care Transition Grants Program**

Period:	September 1989–September 1994
Funding:	$ 21.1 million
Award:	Grants
HCFA Project Officer:	William L. Damrosch Division of Hospital Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) (Amended by section 6003(g)(1)(B) of the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239)

Description: Congress appropriated $21.1 million in fiscal year (FY) 1994 to fund the Rural Health Care Transition Grants program. Funding for FY 1994 provided grants for new awards in 1994, second-year funding for projects awarded in FY 1993, and third-year funding for projects awarded in 1992, as well as an independent evaluation. These grants will support a variety of innovative projects to strengthen the capability of small rural hospitals and their communities to provide high-quality care to Medicare beneficiaries. Under this grants program, eligible rural hospitals may request up to $50,000 per year for up to 3 years. Hospitals receiving awards requested funds to support activities in such areas as enhancing outpatient and/or emergency services, recruiting health professionals, and developing alternative service delivery systems (including rural health care networks) to provide care more effectively. Hospitals qualified for this program if they were non-Federal, not-for-profit, short-term, general acute care hospitals located in rural areas (i.e., those currently being paid as rural hospitals under the Medicare hospital prospective payment system) and had fewer than 100 available beds (as defined in the Medicare Cost Report).

Status: On December 24, 1993 the Office of Research and Demonstrations within the Health Care Financing Administration (HCFA) mailed the solicitation announcement and application materials to each rural hospital. Applications from the hospitals were submitted to HCFA on or before March 15, 1994. HCFA received a total of 346 applications in response to the solicitation. Applications were received from hospitals in each State (except Connecticut, Maryland, Massachusetts, and the Commonwealth of Puerto Rico) in which there were eligible rural hospitals. Delaware, New Jersey, and Rhode Island have no eligible rural hospitals. Each application was reviewed for technical merit by a panel of experts. Of the 129 awards in FY 1994, 98 went to hospitals applying as individual facilities and 31 went to hospitals applying as part of a consortium (8 consortia). Of the grants awarded to hospitals in FY 1993 and FY 1992, 314 hospitals requested and received second-year and third-year continuation funding totaling $14.7 million. HCFA continues to contract with Mathematica Policy Research, Inc., to evaluate the program and to provide technical support in monitoring the program.

91-104 **Rural Health Transition Grant Evaluation: 1991–92** (Formerly, Rural Health Transition Grant Evaluation)

Project No.:	500-91-0075
Period:	September 1991–December 1995
Funding:	$ 1,189,459
Award:	Contract
Principal Investigator:	Valerie Cheh, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 216)
HCFA Project Officer:	Siddhartha Mazumdar, Ph.D. Division of Hospital Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: Mathematica Policy Research, Inc. (MPR), has completed its monitoring of the fiscal years (FY) 1989 and 1990 grantees and is performing post-award functions for the FY 1991, FY 1992, and FY 1993 Rural Health Care Transition grantees, which include:

- Monitoring grantees to determine that grant funds are being expended for the purposes for which they were made.
- Maintaining an ongoing profile of the grantees' progress in planning and/or implementing the components of their programs.
- Reporting to the Health Care Financing Administration the results of the monitoring, the perceived needs of rural hospitals, and the evaluation of the projects and of the impact and effectiveness of the program.

This contract focuses on the monitoring and evaluation of the FY 1991 and FY 1992 grantees.

Status: MPR has recently completed two reports: the eighth semi-annual progress report on the Rural Health Care Transition Grants Program, mandated by congressional statute, and a final report evaluating the grantee projects of FY 1990, which were completed in September 1993. The semi-annual progress report described the progress of FY 1991 and FY 1992 grantees on their projects. The final evaluation report for the 1990 grantees highlighted the difficulties grantee hospitals had in implementing their projects. Especially noted were problems associated with the recruitment and retention of physicians. Also noted in the this report were:

- Local access to specific services has increased inasmuch as grant funding has produced a variety of new services that patients are using; however, overall utilization and services have been unaffected by the grants program.
- Hospitals also faced obstacles in completing their projects because of high rates of administrator turnover.
- Grantee hospitals showed greater success in completing their projects and introducing new services compared with the success of the previous year.
- The closure rate for grantee hospitals is equivalent to the closure rate for small rural hospitals nationwide; the grants program generally has failed to produce consolidation and conversion among hospitals.

94-121 **Rural Health Transition Grant Evaluation: 1993–94**

Project No.:	500-94-0011
Period:	March 1994–January 1998
Funding:	$ 1,121,413
Award:	Contract
Principal Investigator:	Craig Thornton, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Siddhartha Mazumdar, Ph.D. Division of Hospital Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: Mathematica Policy Research, Inc. (MPR), has completed its monitoring of the fiscal years (FY) 1989 and 1990 grantees and is performing post-award functions for the FY 1991, FY 1992, and FY 1993 Rural Health Care Transition grantees, which include:

- Monitoring grantees to determine that grant funds are being expended for the purposes for which they were made.
- Maintaining an ongoing profile of the grantees' progress in planning and/or implementing the components of their programs.
- Reporting to the Health Care Financing Administration the results of the monitoring, the perceived needs of rural hospitals, and the evaluation of the projects and of the impact and effectiveness of the program.

This contract focuses on the monitoring and evaluation of the FY 1993 grantees.

Status: MPR has recently completed two reports: the eighth semi-annual progress report on the Rural Health Care Transition Grants Program, mandated by congressional statute, and a final report evaluating the grantee projects of FY 1990, which were completed in September 1993. The semi-annual progress report described the progress of FY 1991, and FY 1992 grantees on their projects. The final evaluation report for the 1990 grantees highlighted the difficulties grantee hospitals had in implementing their projects. Especially noted were problems associated with the recruitment and retention of physicians. Also noted in the this report were:

- Local access to specific services has increased inasmuch as grant funding has produced a variety of new services that patients are using; however, overall utilization and services have been unaffected by the grants program.
- Hospitals also faced obstacles in completing their projects because of high rates of administrator turnover.
- Grantee hospitals showed greater success in completing their projects and introducing new services compared with the success of the previous year.
- The closure rate for grantee hospitals is equivalent to the closure rate for small rural hospitals nationwide; the grants program generally has failed to produce consolidation and conversion among hospitals.

94-018 **Study of the Natural History of End Stage Renal Disease in Persons with Diabetes**

Project No.:	500-92-0021DO04
Period:	July 1994-December 1995
Funding:	$ 111,074
Award:	Delivery Order in Master Contract
Principal Investigator:	Robert J. Rubin, M.D.
Awardee:	Lewin/VHI, Inc. (See page 213)
HCFA Project Officer:	Paul W. Eggers, Ph.D. Division of Beneficiary Studies

Description: This project will analyze the natural progression of end stage renal disease (ESRD) among persons with diabetes to acquire further knowledge about the risk factors associated with this progression. This will be accomplished by linking the second National Health and Nutrition Examination Survey with the ESRD Program Management and Medical Information System at the Health Care Financing Administration. The cumulative incidence of ESRD among persons identified as diabetic or having impaired glucose tolerance will be calculated and risk factors will be identified.

Status: Relevant variables have been identified, and creation of the files for matching has begun.

91-061 **Technology Change, Medicare Volume Performance Standards, and Medicare Expenditure Growth**

Project No.:	99-C-98168/3
Period:	August 1991–July 1993
Funding:	$ 107,865
Award:	Cooperative Agreement
Principal Investigator:	Karen Stewart
Awardee:	The People-to-People Health Foundation, Inc. (See page 210)
HCFA Project Officer:	Lawrence E. Kucken Division of Beneficiary Studies

Description: This project comprises a detailed empirical analysis of seven medical technologies. It includes a review of current and planned Health Care Financing Administration (HCFA) data systems for measuring the diffusion, use, and cost impacts of new technologies on an ongoing basis. Technologies were chosen along dimensions of cost impact (increasing versus decreasing), clinical impact (diagnostic versus therapeutic), quality impact (enhancing or not), and site of service (i.e., office, hospital, or outpatient center).

Status: A final report has been received by HCFA and is under review.

93-003 **To Strengthen Michigan Families**

Project No.:	11-P-90120/5
Period:	October 1992–September 1997
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Dan Cleary
Awardee:	Michigan Department of Social Services 235 South Grand Avenue P.O. Box 30037 Lansing, MI 48909
HCFA Project Officer:	Alisa Adamo Division of Health Systems and Special Studies

Description: This welfare reform demonstration seeks to strengthen families by encouraging employment, targeting support, increasing responsibility and involving communities. The majority of the waivers were granted by the Administration for Children and Families. Medicaid waivers were granted to enable the State of Michigan to expand sanctions for fraud control by imposing penalties on institutionalized people who divert their jointly owned assets to nonclient owners or to unavailable forms (i.e., single premium, irrevocable annuities). However, this waiver is no longer needed because the Omnibus Budget Reconciliation Act of 1993 allows States to impose penalties on institutionalized individuals who are transferring their assets. The State has recently submitted an application to amend their demonstration by adding several new components. Three of the new components require Medicaid waivers to expand coverage for Medicaid by allowing families leaving transitional medical assistance to purchase health insurance through a managed care plan; allowing noncustodial parents to purchase health insurance through a managed care plan for their children; and providing family planning services for individuals with incomes below 185 percent of the Federal poverty level.

Status: The State's amendment is currently under review in the Health Care Financing Administration.

IM-017 **Trends in Access to Health Care Services for Selected Segments of the Medicare Population**

Funding:	Intramural
HCFA Project Director:	Renee Mentnech Division of Beneficiary Studies

Description: Trend data on access to health care services will be developed for the years prior to, during, and after implementation of physician payment reform (PPR). The focus will be on vulnerable subgroups of the Medicare population such as persons with low income, persons without supplemental medical insurance, and persons with acute and chronic conditions. Geographic differences also will be examined. These trend data will be derived from the National Health Interview Survey conducted by the National Center for Health Statistics. The years 1984, 1986, 1989, 1990, and 1991 will be used to develop pre-PPR baseline data. The years 1992 and 1993 will be used to develop post-PPR data.

Status: Descriptive data for 1984, 1986, 1989, 1990, and 1991 have been developed by sociodemographic characteristics. Relative standard errors have been computed using a software package that takes complex sample designs into account. A multivariate model with 1984, 1986, 1989, and 1990 data has been developed to assess the impact of specific factors on use of physician services. Analysis of these data was incorporated into the 1993 and 1994 Reports to Congress on Access to Physician Services. The 1992 and 1993 Health Interview Survey data will be added to the analyses as soon as they become available.

91-070 **Trends in Access to Physician Services**

Project No.:	99-C-98526/1
Period:	September 1991–April 1993
Funding:	$ 90,749
Principal Investigator:	Stanley Wallack, Ph.D.
Awardee:	Brandeis University (See page 204)
HCFA Project Officer:	Lawrence E. Kucken Division of Beneficiary Studies

Description: The purpose of this project is to provide descriptive statistics on physician service use by various elderly subgroups according to age, race, and urban and rural residence. Data are presented according to the Current Procedural Terminology-4 codes classification scheme and will be based on data from the Part B Medicare Annual Data file for the years 1985–90.

Status: The final report has been accepted by the Health Care Financing Administration and is being sent to the National Technical Information Service. The report shows extensive variation in growth rates across physician services during the study period. In 1990, large variations were found in service rates for different cohorts of Medicare beneficiaries.

93-066 **Uniform Clinical Data Set Algorithm Refinement Project**

Project No.:	500-92-0024DO07
Period:	September 1993–September 1994
Funding:	$ 341,853
Award:	Delivery Order in Master Contract
Awardee:	The Urban Institute (with SysteMetrics, Inc.) (See page 215)
HCFA Project Officer:	Robert P. Connolly Health Standards and Quality Bureau

Description: The Uniform Clinical Data Set System (UCDSS) is a computerized decision support system being developed for use by peer review organizations (PRO) to evaluate the quality of health care data which are used to evaluate both medical necessity for acute care services and quality of care. Within the UCDSS employed by PROs, there are currently five distinct algorithm modules. Three of these are used for determining appropriateness of admission, the other two are quality modules which are based on generic quality screens and discharge status. The UCDSS is currently being piloted in five States. The data collected by the system are used for individual case review by the pilot PROs. The software applies admission necessity and quality algorithms to the data for a particular case and either approves the case or marks (flags) it for physician review. As PROs develop quality improvement projects, UCDSS will become an important source of data for evaluating patient outcomes with respect to specific treatment criteria and the process of care related to a particular diagnosis. The purpose of this project is to refine the disease-specific module of the UCDSS—the Patient Care Algorithm System (PCAS) and quality flags/indicators for four disease processes. The PCAS components are clinical logic that is applied to the clinical data abstracted from medical records to determine if further PRO review is needed. The disease process modules included in this Scope of Work are: Cardiac dysrhythmias (two groups), diabetes mellitus, urinary tract infection, and female breast cancer.

Status: The project has just completed the final module, diabetes mellitus. The final report is being finalized.

IM-025 Upper Gastrointestinal Endoscopy in the United States: Geographic Variation in Practice Patterns

Funding:	Intramural
HCFA Project Director:	Renee Mentnech Division of Beneficiary Studies

Description: Upper esophagogastroduodenoscopy (EGD) is a commonly performed procedure with well-defined indications. However, little is known about the practice patterns for this procedure, specifically the number performed. The purpose of this study is to examine variations in the use of endoscopy on Medicare patients in the United States and how variations in endoscopy rates relate to variations in the rates of hospitalizations for gastrointestinal disorders.

Status: All aged Medicare patients who underwent EGD in 1991 and 1992 were identified using Current Procedural Terminology codes. Rates of endoscopy for the top 50 metropolitan statistical areas by gender and race were compared. Hospitalization rates for diagnoses for which an EGD is indicated also were compared. The supply of gastroenterology training programs for physicians is being examined to determine the affect on utilization. A paper is being prepared for publication.

IM-019 Use of Rural/Urban Inpatient Facilities by Rural Medicare Beneficiaries

Funding:	Intramural
HCFA Project Director:	William Buczko, Ph.D. Division of Payment and Economic Studies

Description: This project has examined the extent to which rural Medicare beneficiaries receive inpatient care in rural or in urban hospitals.

Status: Recent project research has examined the extent to which rural Medicare beneficiaries in several States are hospitalized in local rural hospitals, other rural hospitals, or in urban hospitals. Initial findings examining hospitalizations for rural Delaware beneficiaries were presented at the 1993 Annual Meeting of the American Public Health Association (APHA) and appear in the article, "Bypassing of Local Hospitals by Medicare Beneficiaries," by William Buczko in *The Journal of Rural Health*, 10(4):237–246, Fall 1994. Research findings on hospitalizations of Minnesota and Kentucky rural Medicare beneficiaries will be presented at the 1994 Annual Meeting of APHA.

92-066 Utah Welfare Reform: Single Parent Employment Demonstration

Project No.:	11-W-00019/8
Period:	September 1992–October 1996
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Kerry Steadman
Awardee:	Utah Department of Human Services P.O. Box 45500 Salt Lake City, UT 84145-0500
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Health Care Financing Administration, the Administration for Children and Families, and the Department of Agriculture (Food Stamps). Under this project, to divert them from welfare, applicants for Aid to Families with Dependent Children (AFDC) who appear to have short-term need are given a one-time cash payment equivalent to 3 months of an AFDC grant and 3 months of Medicaid coverage in Utah. Those with longer term need receive a cash equivalent of Food Stamps, regular monthly AFDC payments, and an incentive payment to participate in employment-related activities, with a larger financial deterrent for nonattendance. Those who become employed receive a higher disregard of earnings than current law allows, and those who work their way off welfare receive 12 months of Food Stamp cash equivalent and a 12-month Medicaid extension, with no income limit during the extension period. (Current law provides a 6-month Medicaid extension, regardless of income, with an additional 6 months contingent upon earnings below 185 percent of the Federal poverty level.)

Status: Preliminary results as of July/August 1994 indicate that:

- Nearly a quarter (24 percent) of the cases in the experimental group had earned income, in contrast to 16 percent in the control group, and average monthly earnings were $465 for the experimental group, in contrast to $407 for the control group.
- In contrast to the control group, twice as many of the experimental cases worked their way off AFDC and into the Medicaid transition benefit.
- In one experimental county, only 23 percent of the participants working 30 or more hours per week, and 4 percent of those working fewer hours, had access to health insurance through their employer. In another experimental county, 68 percent of persons in full-time positions (undefined) and 14 percent of those in part-time positions had such access.

- Of the 195 cases given a diversion payment, 89 percent remained off the welfare rolls.

The State has requested an extension of the demonstration to December 31, 2000.

IM-016 Utilization and Evaluation (Effectiveness and Cost Effectiveness) of Pneumococcal Vaccine in the Medicare Program

Funding: Intramural
HCFA Project Director: A. Marshall McBean, M.D.
Division of Beneficiary Studies

Description: The Immunization Practice Advisory Committee of the Public Health Service recommends the pneumococcal vaccine for all people 65 years of age or over, and Medicare has reimbursed for this preventive service since July 1981. The national goal is to immunize 60 percent of Medicare beneficiaries with the pneumococcal vaccine by 1990. The current immunization level is estimated to be approximately 10 percent. In 1985, Medicare reimbursed for the administration of almost 460,000 doses of vaccine and there were approximately 1,750,000 new Medicare enrollees. Although the vaccine is recommended by the Committee, the effectiveness of the vaccine was questioned as a result of one randomization control trial published in 1986 and one unpublished study, both done on Veterans Administration beneficiaries. Researchers will describe vaccine utilization as well as the effectiveness and cost effectiveness of the vaccine for Medicare beneficiaries. The project has four major aspects:

- Part 1 will describe the utilization of pneumococcal vaccine for Medicare beneficiaries in 1985–88 using the Part B Medicare Annual Data procedure and beneficiary files and the Health Insurance Skeleton Eligibility Write Off file. The characteristics of immunized and nonimmunized beneficiaries will be examined, as well as those of the providers of the vaccine, to identify ways of increasing coverage.
- Part 2 will be a case control study of the effectiveness and the cost effectiveness of pneumococcal vaccine using all Medicare provider analysis and review file reported cases of pneumococcal bacteremia and pneumococcal pneumonia in the United States as the outcome.
- Part 3 will evaluate the effectiveness and cost effectiveness of a pneumococcal vaccine program administered by county health departments in collaboration with the Baltimore County Health Department and the Johns Hopkins Center on Aging.
- Part 4 will evaluate the effectiveness of the statewide pneumococcal vaccine program in Hawaii in reducing morbidity and hospital costs following pneumococcal polysaccharide vaccine.

Status: Major project activities include:

- Part 1 Utilization of pneumococcal vaccine for Medicare beneficiaries in 1985–88

Results were published in McBean, A.M., Babish, J.D., Warren, J.L.:The impact and cost of influenza in the elderly. *Arch Intern Med.* 153:2105-2111, 1993.

- Part 2 Case control study of the effectiveness and the cost effectiveness of pneumococcal vaccine

No further progress.

- Part 3 Evaluation of the effectiveness and cost effectiveness of a pneumococcal vaccine program

In county-sponsored clinics in Anne Arundel, Baltimore, Carroll, Harford, and Howard counties, Maryland, more than 10,000 Medicare beneficiaries received either pneumococcal or influenza vaccine in preparation for the 1987–88 and 1988–89 influenza seasons. Approximately 3,000 have received the pneumococcal vaccine. The entire population is being followed for hospitalizations resulting from various categories of pneumonia.

- Part 4 Evaluation of the effectiveness of the statewide pneumococcal vaccine program in Hawaii

Hawaii carried out its pneumococcal vaccine immunization program on the island of Oahu and the neighboring islands from September 1988 through February 1989 and administered more than 15,000 doses of vaccine on Oahu. A cohort study based on the data from the Hawaii immunization campaign and that from 1982–88 from the Medicare Part B carrier has been started. The date of immunization for those who received the vaccine will be known, and the incidence of hospitalization for pneumococcal and other illnesses in this group will be compared with that for nonimmunized beneficiaries. A study to validate the immunization information obtained from the carrier has been carried out and has substantiated the validity of that information. Work has begun on measuring the effect of the vaccine on rates of hospitalization for pneumonia.

IM-029 **Utilization of Services and Expenditures among Children Enrolled in Medicaid: Descriptive Analyses**

Funding:	Intramural
HCFA Project Director:	Leslye Fitterman Division of Beneficiary Studies

Description: This project examined the utilization of Medicaid-covered health services and the total expenditures provided to children in Tennessee and Michigan in 1990. Data came from the Medicaid Analysis Project of States. The study examined inpatient, outpatient, and prescription medication claims for all children 18 years of age or under as of December 31, 1990 and who were enrolled continuously throughout the year. The analyses and manuscripts are a collaborative effort of the Health Care Financing Administration's (HCFA) project director, Jeff Buck, and Anne Trontell, all from HCFA's Office of Research.

Status: Two manuscripts are being prepared for possible publication. The first describes the utilization and expenditures of the two Medicaid juvenile populations with a subanalysis on the children who incurred the highest expenditures. The second examines the mental health utilization and expenditures for children in the Medicaid programs of Michigan and Tennessee.

93-063 **Vermont Welfare Reform: Family Independence Project** (Formerly, Vermont Family Independent Program)

Project No.:	11-P-90238/1
Period:	July 1993-June 2001
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Cornelius Hogan
Awardee:	Vermont Agency of Human Services 103 South Main Street Waterbury, VT 05676
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Health Care Financing Administration, the Administration for Children and Families, and the U.S. Department of Agriculture (Food Stamps). The demonstration requires single-parent cases in Vermont who have been eligible for Aid to Families with Dependent Children (AFDC) for more than 30 months, and two-parent cases who have been eligible for AFDC for more than 15 months, to participate in subsidized employment. Demonstration waivers also broaden AFDC eligibility for two-parent cases; require most parents of minors to live in a supervised setting; increase the disregard of earnings and assets, in determining AFDC eligibility; permit disbursement of child support payments to the AFDC family; permit the State to give incentive payments to AFDC parents who successfully complete parenting education classes or other approved activities; and make income eligibility the same for AFDC and Food Stamps. Medicaid waivers allow families who work their way off welfare to have a maximum 36-month Medicaid transition benefit, in quarterly increments, as long as the family's income is below 185 percent of the Federal poverty level (in lieu of current law's maximum 12-month Medicaid transition benefit).

Status: Demonstration waivers were implemented July 1, 1994.

94-070 **Virginia Welfare Reform Demonstration**

Project No.:	11-W-00013/3
Period:	November 1993-October 1997
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Carol A. Brunty
Awardee:	Virginia Department of Social Services 8007 Discovery Drive Richmond, VA 23229-8699
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Health Care Financing Administration and the Administration for Children and Families. The project increases the resource limit for housing and education, and extends Aid to Families with Dependent Children (AFDC) eligibility to full-time students until they reach 21 years of age. It also changes the method of counting stepparent income. In addition, it permits adults who have been on welfare for at least 2 years to volunteer for jobs expected to pay $15,000-$18,000 per year, with initial training stipends equal to the AFDC grant. Furthermore, the project establishes a child support insurance program for clients leaving AFDC because of earnings. Finally, the project extends the Medicaid and child care transition benefit periods to 36 months in four localities, and to 24 months elsewhere in the State, but cases lose eligibility in the second and third years of the transition benefit if their income exceeds 150 percent of the Federal poverty level.

Status: This project is in the early implementation phase; however, the 36-month transition benefit will not be implemented.

88-019 **Washington State Welfare Reform: Family Independence Program**

Project No.:	11-C-99582/0
Period:	July 1988–June 1993
Funding:	Waiver only
Award:	Cooperative Agreement
Principal Investigator:	Jean Soliz
Awardee:	Washington State Department of Social and Health Services P.O. Box 45010 Olympia, WA 98504-5010
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: This demonstration had waivers from the Health Care Financing Administration, the Administration for Children and Families (ACF) and the Department of Agriculture (Food Stamps). In the experimental areas of the State of Washington, recipients of Aid to Families with Dependent Children (AFDC) received the cash equivalent of the value of food stamps and, as an incentive to become employed, were given larger welfare benefits if they accepted work-related training; were permitted to keep larger proportions of their earnings if they worked; and were granted a 12-month Medicaid extension when they worked their way off welfare, regardless of income increases during the extension period. (Current law provides a 6-month Medicaid extension, regardless of income, with an additional 6 months contingent upon earnings below 185 percent of the Federal poverty level.)

Status: Waivered benefits ended June 30, 1993, and the evaluator, Urban Institute, has submitted the last in a series of reports. Prominent findings are:

- The Family Independence Program (FIP) increased the number of single-parent cases receiving welfare by 2 to 3 percent, and the number of two-parent cases by more than 33 percent.
- FIP clients stayed on welfare longer and returned to welfare more quickly than did AFDC clients, although the difference was not statistically significant.
- Participation in education and training, rates of employment, and earnings were not significantly different from those of AFDC clients.
- Almost 40 percent of families were unaware of the availability of transitional child care and Medicaid benefits.

Overall, the evaluator found that FIP did not have the expected impacts on clients' ability to achieve independence from welfare.

88-002 **Wisconsin State Welfare Reform Demonstration** (Formerly, Wisconsin Welfare Reform Demonstration)

Project No.:	11-W-00041/5
Period:	October 1987–July 1994
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Gerald Whitburn
Awardee:	Wisconsin State Department of Health and Social Services P.O. Box 7850 Madison, WI 53707-7850
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Administration for Children and Families (ACF) permitting:

- A requirement that some persons receiving Aid to Families with Dependent Children (AFDC) work 40 hours per week rather than the law's current limit of 20 hours.
- Major changes in the disregard of earnings, with less being disregarded in the initial 4 months of work and more in the subsequent 8 months.
- A Medicaid extension of 12 months for recipients who lose AFDC eligibility because of earnings, regardless of income increases during the extension period. (Current law provides a 6-month Medicaid extension, regardless of income, with an additional 6 months contingent upon earnings below 185 percent of the Federal poverty level [FPL].)

Wisconsin implemented its Medicaid extension waiver in February 1989. During the third year of the welfare reform demonstration, the Health Care Financing Administration (HCFA) approved waivers permitting the State to expand Medicaid eligibility for pregnant women and for children under 2 years of age with family incomes up to 155 percent of the FPL under the Healthy

Start Program. The costs of services were supported through savings generated from the welfare reform demonstration.

Status: As of August 1, 1994, the State began to operate the Healthy Start Program under the Omnibus Budget Reconciliation Act of 1987 provisions specified in section 1902(i)(2), and no longer required waivers for this program. The State has requested an extension of the ACF and HCFA welfare reform waivers through September 1997. ACF has extended its waivers for 1 year, contingent upon the State documenting the evaluation that is to be undertaken. HCFA is reviewing the State's request.

92-042 **Wisconsin Welfare Reform: Two-Tier Aid to Families with Dependent Children Benefit Demonstration** (Formerly, Two-Tier Aid to Families with Dependent Children Benefit Demonstration)

Project No.:	11-P-90167/5
Period:	July 1992–January 1999
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Gerald Whitburn
Awardee:	Wisconsin State Department of Health and Social Services P.O. Box 7850 Madison, WI 53707-7850
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: The project will measure the impact of Aid to Families with Dependent Children (AFDC) benefit levels on interstate migration among low-income families. This will be accomplished by paying families in up to six selected counties at a rate based on the benefit rate in their State of prior residence during their first 6 months in Wisconsin. Under the demonstration, a family will receive a benefit amount available to a typical family of the same size in the prior State of residence if the recipient applies for benefits within 180 days after moving to Wisconsin. A waiver of section 1902(c)(1), the maintenance of effort provision of the Medicaid law, has been approved to permit the State to obtain approvals of new State plans for medical assistance even though the AFDC payment levels under the project will be below those levels in effect as of May 1, 1988. In addition, under the authority of section 1115(a)(2) of the Social Security Act, the following expenditures will be regarded as expenditures under the State's Title XIX plan: expenditures to permit the State to maintain the eligibility level for its Medically Needy program at 133 1/3 percent of the current AFDC payment level, as specified under section 1903(f)(1), while the State reduces payments under the Two-Tier AFDC Benefit Demonstration.

Status: Waivers have been approved for a 5-year period. The implementation date coincided with first-phase implementation of the State's automated eligibility system on July 1, 1994. The evaluation contract was awarded on August 1, 1993 to Mathematica Policy Research, Inc.

94-067 **Wisconsin Welfare Reform: Work Not Welfare**

Project No.:	11-W-00009/8
Period:	November 1993–December 2005
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Gerald Whitburn
Awardee:	Wisconsin State Department of Health and Social Services P.O. Box 7935 Madison, WI 53707-7935
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This demonstration has waivers from the Health Care Financing Administration (HCFA), the Administration for Children and Families, and the Department of Agriculture (Food Stamps) to:

- Consolidate the Aid to Families with Dependent Children (AFDC) grant and Food Stamps into a single cash payment.
- Provide no increase in the cash grant for children born on welfare.
- Limit cash benefits to 24 months in a 60-month period.
- Eliminate the restriction on hours of employment for two-parent families.
- Limit the family to 12 months of Medicaid and child care transition benefits within a 48-month period.
- Permit the State to require that recipients pay a premium for health insurance that exceeds 3 percent of their income during any part of the transition benefit period (current law limits this to the second 6 months of the 12-month transition period).

Status: This project is in the early implementation phase for most waivers. The State has not yet implemented the imposition of a premium payment and will negotiate the details of this premium payment with HCFA.

Service Delivery Systems

93-049 Analysis of Expansion of Access to Care through the Use of Telemedicine and Mobile Health Services

Project No.:	500-92-0046DO02
Period:	June 1993–February 1995
Funding:	$ 264,259
Award:	Delivery Order in Master Contract
Principal Investigator:	Robert E. Schlenker, Ph.D.
Awardee:	Center for Health Policy Research (See page 209)
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: The objective of this task is to analyze the issues and unanswered questions associated with telemedicine and mobile health services technologies as they relate to the development of a Medicare coverage policy. The primary focus of the study will be telemedicine. The task will be divided into three components: a comprehensive review of the literature, a case study report based on eight indepth site visits, and an analysis of coverage policies of other third party payers. Findings from each of the three components will be consolidated into a final report.

Status: Each of the three individual component reports has been finalized. In addition, the final report, incorporating findings from the initial three reports as well as the technical advisory panel meeting convened in July 1994, has been submitted in draft and will be completed by the end of the year. Finalized reports are being submitted to the National Technical Information Service.

94-052 Availability and Effective Use of Pediatric and Family Nurse Practitioners under State Medicaid Programs

Project No.:	18-C-90310/4
Period:	September 1994–September 1995
Funding:	$ 152,002
Award:	Cooperative Agreement
Principal Investigator:	Dale C. Jones
Awardee:	Research Triangle Institute P.O. Box 12194 3040 Cornwallis Road Research Triangle Park, NC 27709
HCFA Project Officer:	Gloria Smiddy Division of Program Studies

Description: The primary objectives of this study are to assess the availability of family and pediatric nurse practitioners to provide services to the Medicaid population and to describe the extent to which nurse practitioners are caring for Medicaid patients. The main sources of data will be two national surveys of advance practice nurses, conducted in the early 1990s.

Status: This project is in the early developmental phase.

94-065 Bundle Payment for Physician and Hospital Services Using Telemedicine Services

Project No.:	95-C-90384/3
Period:	July 1994–July 1997
Funding:	$ 993,310
Award:	Cooperative Agreement
Principal Investigator:	William W. Reeves
Awardee:	West Virginia University Research Corporation Office of Sponsored Programs P.O. Box 6845 Morgantown, WV 26506-6845
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: This project will investigate whether changing the current Medicare payment policy for telemedicine will enhance patients' access to care and improve the quality of care delivered in rural communities while limiting the growth of health care spending. West Virginia University's Mountaineer Doctor Television (MDTV) program currently links five rural spoke sites (Davis Memorial Hospital, Wetzel County Hospital, Grant Memorial Hospital, Boone Memorial Hospital, and St. Joe's Hospital) with two hub sites (the Robert C. Byrd Health Sciences Center in Morgantown and Charleston Area Medical Center). While hospital and administrative expenses will be covered under the cooperative agreement award funding, payment for related physician services will be made under the auspices of a waiver of Medicare payment regulations. The major objective of the project is the development of a payment system for inpatient telemedicine consultations. Related objectives include developing a coding system for inpatient telemedicine consultations, increasing the number of inpatient telemedicine consultations, and reducing interhospital transfers by 50 percent. The effect of the payment system on the number and types of charges generated by Medicare patients at rural MDTV sites will be evaluated. The cost effectiveness and feasibility of telemedicine followup for patients returned from the referral center back to the rural hospitals for the

remainder of their hospitalization will be evaluated. A plan for payment of outpatient telemedicine consultations also will be developed.

Status: This project is in the early developmental stage.

93-020 Case-Mix Classification for Home Health Agencies

Project No.:	97-P-08057/9
Period:	February 1993–January 1994
Funding:	$ 25,076
Award:	Grant
Principal Investigator:	James M. Cameron, Ph.D.
Awardee:	Health Systems Research, Inc. 2385 Garden Highway Sacramento, CA 95833
HCFA Project Officer:	Leslie A. Mangels Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The purpose of this project was to develop a patient classification system for home health care. The basic approach for classification was the definition of patient groups (or case types) using patient assessment variables as determinants of home health care resources use.

Status: Phase I (development) was completed; however, Phase II (testing and data gathering) was not funded. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

94-108 Congestive Heart Failure Outreach Project

Project No.:	18-P-90365/5
Period:	September 1994–September 1997
Funding:	$ 830,395
Award:	Grant
Principal Investigator:	Joseph P. Malone, M.D.
Awardee:	Miami Valley Hospital One Wyoming Street Dayton, OH 45409
HCFA Project Officer:	Renee Mentnech Division of Beneficiary Studies

Description: Miami Valley Hospital is a large hospital in Ohio with 811 beds. This hospital, in cooperation with Wright State University-Miami Valley School of Nursing, will analyze whether post-hospital education and intensive case management can reduce rehospitalization rates for congestive heart failure (CHF) patients. All patients admitted to the hospital with a CHF diagnosis and discharged to a home will be assigned to case management followup or to standard post-hospital care.

Status: This project is in the developmental phase.

91-088 Coordinating Care for Pregnant Substance Abusers Demonstration: Maryland

Project No.:	11-C-06103/3
Period:	September 1991–December 1996
Funding:	$ 1,300,000
Award:	Cooperative Agreement
Principal Investigator:	Mary E. Stuart, Sc.D.
Awardee:	Maryland Department of Health and Mental Hygiene 201 West Preston Street, Room 225 Baltimore, MD 21201
HCFA Project Officer:	Sherrie L. Fried Division of Health Systems and Special Studies

Description: For this project, pregnant substance abusers who reside in specific areas in eastern Baltimore City are targeted. The project will demonstrate the costs and effectiveness of two innovative methods of outreach for Medicaid-eligible substance abusers. The first outreach strategy makes use of aggressive clinical case management to link medical and substance abuse service. The second outreach strategy is the substance abuse support group that meets twice weekly on site in the Johns Hopkins Hospital Prenatal Care clinic. The Johns Hopkins University is participating in the evaluation of the demonstration. The project does not require waivers. Participants can receive targeted case management under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, permitting targeted case management to Medicaid recipients.

Status: Although service delivery began in 1993, enrollment rates have been lower than anticipated. Twice weekly support groups are conducted on site at the prenatal care clinic. The project will be interviewing women in another site and enrolling them into the control group. In addition, community outreach workers will receive training on the identification and referral of

eligible women into the program. The project hopes that this will increase enrollment.

91-087 Coordinating Care for Pregnant Substance Abusers Demonstration: Massachusetts

Project No.:	11-C-06111/1
Period:	September 1991–December 1996
Funding:	$ 1,125,000
Award:	Cooperative Agreement
Principal Investigator:	Dennis McCarty
Awardee:	Massachusetts Department of Public Welfare 180 Tremont Street, 13th Floor Boston, MA 02111
HCFA Project Officer:	Deborah C. Van Hoven Division of Health Systems and Special Studies

Description: The focus of this project is on enhancing current service linkage and delivery efforts in the Boston and Holyoke areas. The Massachusetts project, referred to as the "MOTHERS" project, consists of two interrelated, yet distinct studies. Study One, which operated until January 1994, addressed strategies for identifying and bringing Medicaid-eligible pregnant substance abusers into prenatal care and substance abuse treatment. The project drew heavily on a prenatal care initiative referred to as the Perinatal Community Initiatives Project (PCIP), which, prior to State reorganization of the program, included community outreach and case finding, comprehensive case management for high-risk women, and linkage with other relevant services. A study is now being conducted of PCIP personnel to determine barriers and potential conflicts when utilizing indigenous individuals for projects in similar communities. Study Two, which is funded by the Health Care Financing Administration and is ongoing, compares free standing and hospital-based substance abuse detoxification and treatment in residential and outpatient settings.

Status: The project received waiver approval for a 3-year period, beginning July 1, 1993, through June 30, 1996. Screening is being conducted in the PCIPs and followup interviews are being conducted for women who have received detoxification, followed by residential or ambulatory treatment services.

91-086 Coordinating Care for Pregnant Substance Abusers Demonstration: New York

Project No.:	11-C-06115/2
Period:	September 1991–December 1996
Funding:	$ 1,700,000
Award:	Cooperative Agreement
Principal Investigator:	Barbara McManaman
Awardee:	New York State Department of Social Services Division of Medical Assistance 40 North Pearl Street Albany, NY 12243-0001
HCFA Project Officer:	Sherrie L. Fried Division of Health Systems and Special Studies

Description: The project has six sites, three in New York City and three in upstate areas of New York. Approximately 430 eligible women are targeted for services. As adjuncts to the standard substance abuse treatment services, the following services will be provided: perinatal care, pediatric care, developmental screening, health education, family planning, parenting education, nutritional counseling, child care, vocational assessment, self-esteem building, and transportation. The project will include residential treatment programs.

Status: The project has received waiver approval for a 3-year period, beginning July 1, 1993, through June 30, 1996. New York is experiencing a major problem with enrollment of recipients into the demonstration. The problems are most severe in the New York City sites. The Health Care Financing Adaministration has approved a revision to the demonstration design which will allow the providers to eliminate the ZIP Code requirements in providing services to demonstration participants. To encourage provider participation, New York has changed the reimbursement rate for residential providers and is attempting to revise the rates for ambulatory providers. The State will be resoliciting the residential providers to encourage their participation in the demonstration. The State has scheduled additional training for the lead agencies in the New York City sites to increase enrollment rates.

91-085 Coordinating Care for Pregnant Substance Abusers Demonstration: South Carolina

Project No.:	11-C-06112/4
Period:	September 1991–December 1996
Funding:	$ 1,441,000
Award:	Cooperative Agreement

Principal Investigator: Eugene Laurent
Awardee: South Carolina State Health and Human Services Finance Commission
P.O. Box 8206
Columbia, SC 29202-8206
HCFA Project Officer: Deborah C. Van Hoven
Division of Health Systems and Special Studies

Description: The South Carolina "Transitions" project was implemented in the Edisto Health District, a tri-county area in the central part of the State that includes Calhoun, Orangeburg, and Bamberg Counties. The three major components of the project are outreach, perinatal/substance abuse clinical services, and evaluation. Other services to be provided include: focused maternal outreach using trained outreach workers, hospital-based detox and residential treatment, intensive in-home services, as well as transportation, child care, child developmental assessments, and other support services. The awardee, South Carolina State Health and Human Services Finance Commission, developed and finalized a reorganization of the clinical, outreach, and administrative components of the program after the DAWN Center, the substance abuse service provider, suddenly suspended treatment services. The Department of Alcohol and Other Drug Abuse Services will be vested with program oversight for alcohol/drug treatment; street and community outreach; and local interagency coordination activities. The transfer will promote improved clinical/medical management and increase the quality and consistency of care provided. The State estimates that approximately 250 women and their infants will receive services during the operational phase of the demonstration.

Status: The project has received waiver approval for a 3-year period, beginning July 1, 1993, through June 30, 1996. The outreach component has been initiated and eligible participants are being enrolled in the project.

91-096 Coordinating Care for Pregnant Substance Abusers Demonstration: Washington

Project No.: 11-C-06108/2
Period: September 1991–July 1996
Funding: $ 1,125,000
Award: Cooperative Agreement
Principal Investigator: Kathy Apadoca
Awardee: Washington State Department of Social and Health Services
Office of First Steps
Mail Stop OB-45A
Olympia, WA 98504
HCFA Project Officer: Alisa Adamo
Division of Health Systems and Special Studies

Description: The Washington State project, referred to as Yakima First Steps Mobilization Project for Substance Abusing Pregnant Women: First Steps Plus, is being conducted in Yakima County, the seventh largest county in the State. Yakima County was selected because it has a high incidence of substance abuse, and the proportion of Medicaid-eligible women is higher than the norm for the State. The First Steps Plus project provides a continuum of care for low-income, pregnant substance abusers. Medicaid maternity care services provided through Washington's First Steps program are combined or coordinated with chemical addiction treatment and social services. Project services are provided throughout pregnancy, delivery, and for up to 1 year post-delivery. The project expands the range of Medicaid services and increases coordination of the service delivery community through communication, collaboration, and training. Additional Medicaid services being provided to the demonstration clients include:

- Expanded outreach activities and expedited substance abuse assessment using a mobile assessment worker.
- Added treatment options of short-term residential treatment and specialized medical stabilization, detoxification, and treatment slots.
- Expended case management, maternity support services, and therapeutic child care.

Approximately 800 women and their children are expected to receive demonstration services during the 3-year operational phase.

Status: Waivers have been approved. Washington began enrolling eligible substance abusing pregnant women and began providing services under the demonstration on July 1, 1993. As of June 1994, 1,859 pregnant women were screened for substance abuse risk factors, 184 women were referred to substance abuse assessment, 166 assessments were completed, and 96 women entered treatment.

93-079 Demonstration Project for Preventive and Primary Pediatric Care: Maryland

Project No.: 11-W-00003/3
Period: September 1993–August 1998

Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Joseph M. Millstone
Awardee:	Maryland Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201
HCFA Project Officer:	Sherrie L. Fried Division of Health Systems and Special Studies

Description: Waivers have been approved for a 5-year period, beginning September 1, 1993, to cover children under Medicaid who meet the following criteria: born after September 30, 1993; are between 1 and 19 years of age; are not currently eligible for the Medicaid program; and are living in families whose income does not exceed 185 percent of the Federal poverty level, with no resource limitation. Maryland intends to demonstrate that access to basic primary care and preventive services increases the utilization of such services, improves health outcome, and is cost effective by preventing acute and chronic medical conditions. No hospital inpatient, outpatient, or emergency room coverage will be provided under the demonstration.

Status: Enrollment has been lower than anticipated, despite extensive outreach efforts. Currently, there are 2,322 children enrolled. The State is working on various strategies to increase enrollment. Additional efforts are being made to increase the number of health centers that are initial processing sites.

94-063 Effects of Telemedicine on Accessibility, Quality, and Cost of Health Care

Project No.:	18-C-90332/5
Period:	July 1994–July 1997
Funding:	$ 644,086
Award:	Cooperative Agreement
Principal Investigator:	F. W. Womack
Awardee:	The University of Michigan 3003 South State Street Ann Arbor, MI 48109-1274
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: The proposed research will evaluate the effects of the telemedicine systems on accessibility, quality, and cost of health care. A detailed methodology for evaluating telemedicine will be developed by a panel of experts and implemented in existing telemedicine programs at the Medical College of Georgia (MCG) Telemedicine Center and Mountaineer Doctor Television (MDTV) at the Health Sciences Center, West Virginia University (WVU). Included in the evaluation design are a quasi-experimental survey study of clients and providers in selected experimental and control communities and a case control study to compare the content, process, and outcomes of episodes of care with and without telemedicine. The proposed project consists of three goals: developing a detailed methodology for a comprehensive evaluation of the effects of telemedicine on accessibility, utilization, quality, and cost of health care, using a distinguished panel of experts on quality, economics, clinical medicine, and technology; implementing and testing the evaluation design at the MCG Telemedicine Center; and extending the evaluation design to MDTV at WVU. The general hypothesis guiding this research is that telemedicine will improve accessibility to health care, enhance the quality of care delivered, and contain costs.

Status: This project is in the early developmental stage.

91-089 Essential Access Community Hospital/Rural Primary Care Hospital Program: California

Project No.:	60-P-07011/9
Period:	September 1991–September 1995
Funding:	$ 1,618,302
Award:	Grant
Principal Investigator:	Ernesto Iglesias
Awardee:	Office of Statewide Health Planning and Development Division of Health Projects and Analysis 1600 9th Street, Room 440 Sacramento, CA 95814
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, the establishment of rural health networks, and the regionalization and integration of services. The EACH/RPCH program consists of: a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services; and a grant program to provide funds to States and hospitals

to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1994, HCFA has awarded a total of $21.7 million in grant funds to these States and 96 hospitals within these States for program planning and participation. Regulations governing program operations (42 CFR Part 400 *et al.*) were published in the *Federal Register* and became effective June 25, 1993.

Status: The State of California is one of seven States participating in the EACH/RPCH program. Since 1991, the California Office of Statewide Health Planning and Development and seven hospitals within the State have received funding to assist in program planning, development, and implementation.

91-090 Essential Access Community Hospital/Rural Primary Care Hospital Program: Colorado

Project No.:	60-P-07006/8
Period:	September 1991–September 1995
Funding:	$ 4,202,645
Award:	Grant
Principal Investigator:	Louise Singleton
Awardee:	Colorado Department of Health Rural and Primary Health Policy and Planning 4300 Cherry Creek Drive, South Denver, CO 80222-1530
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, the establishment of rural health networks, and the regionalization and integration of services. The EACH/RPCH program consists of: a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services; and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1994, HCFA has awarded a total of $21.7 million in grant funds to these States and 96 hospitals within these States for program planning and participation. Regulations governing program operations (42 CFR Part 400 *et al.*) were published in the *Federal Register* and became effective June 25, 1993.

Status: The State of Colorado is one of seven States participating in the EACH/RPCH program. Since 1991, the Colorado Office of Rural and Primary Health Policy and Planning and 16 hospitals within the State have received funding to assist in program planning, development, and implementation.

91-091 Essential Access Community Hospital/Rural Primary Care Hospital Program: Kansas

Project No.:	60-P-07017/7
Period:	September 1991–September 1995
Funding:	$ 5,446,570
Award:	Grant
Principal Investigator:	Richard Morrissey
Awardee:	Kansas Department of Health and Environment Office of Local and Rural Health Systems Landon State Office Building 900 SW. Jackson Topeka, KS 66612-1290
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, the establishment of rural health networks, and the regionalization and

integration of services. The EACH/RPCH program consists of: a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services; and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1994, HCFA has awarded a total of $21.7 million in grant funds to these States and 96 hospitals within these States for program planning and participation. Regulations governing program operations (42 CFR Part 400 *et al.*) were published in the *Federal Register* and became effective June 25, 1993.

Status: The State of Kansas is one of seven States participating in the EACH/RPCH program. Since 1991, the Kansas Office of Local and Rural Health Systems and 29 hospitals within the State have received funding to assist in program planning, development, and implementation.

91-092 Essential Access Community Hospital/Rural Primary Care Hospital Program: New York

Project No.:	60-P-07015/2
Period:	September 1991–September 1995
Funding:	$ 1,997,434
Award:	Grant
Principal Investigator:	Paul FitzPatrick
Awardee:	State of New York Department of Health Office of Rural Health Room 1656 Corning Tower Empire State Plaza Albany, NY 12237
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, the establishment of rural health networks, and the regionalization and integration of services. The EACH/RPCH program consists of: a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services; and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1994, HCFA has awarded a total of $21.7 million in grant funds to these States and 96 hospitals within these States for program planning and participation. Regulations governing program operations (42 CFR Part 400 *et al.*) were published in the *Federal Register* and became effective June 25, 1993.

Status: The State of New York is one of seven States participating in the EACH/RPCH program. Since 1991, the New York State Office of Rural Health and six hospitals within the State have received funding to assist in program planning, development, and implementation.

91-093 Essential Access Community Hospital/Rural Primary Care Hospital Program: North Carolina

Project No.:	60-P-07012/4
Period:	September 1991–September 1995
Funding:	$ 3,836,209
Award:	Grant
Principal Investigator:	James D. Bernstein
Awardee:	North Carolina Department of Human Resources Office of Rural Health and Resource Development 311 Ashe Avenue Raleigh, NC 27606
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH)

program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, the establishment of rural health networks, and the regionalization and integration of services. The EACH/RPCH program consists of: a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services; and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1994, HCFA has awarded a total of $21.7 million in grant funds to these States and 96 hospitals within these States for program planning and participation. Regulations governing program operations (42 CFR Part 400 *et al.*) were published in the *Federal Register* and became effective June 25, 1993.

Status: The State of North Carolina is one of seven States participating in the EACH/RPCH program. Since 1991, the North Carolina Office of Rural Health and Resource Development and 14 hospitals within the State have received funding to assist in program planning, development, and implementation.

91-094 Essential Access Community Hospital/Rural Primary Care Hospital Program: South Dakota

Project No.:	60-P-07023/8
Period:	September 1991–September 1995
Funding:	$ 2,133,946
Award:	Grant
Principal Investigator:	Doug Knutson
Awardee:	South Dakota Department of Health Office of Rural Health 445 East Capitol Avenue Pierre, SD 57501-3185
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, the establishment of rural health networks, and the regionalization and integration of services. The EACH/RPCH program consists of: a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services; and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1994, HCFA has awarded a total of $21.7 million in grant funds to these States and 96 hospitals within these States for program planning and participation. Regulations governing program operations (42 CFR Part 400 *et al.*) were published in the *Federal Register* and became effective June 25, 1993.

Status: The State of South Dakota is one of seven States participating in the EACH/RPCH program. Since 1991, the South Dakota Office of Rural Health and 12 hospitals within the State have received funding to assist in program planning, development, and implementation.

91-095 Essential Access Community Hospital/Rural Primary Care Hospital Program: West Virginia

Project No.:	60-P-07008/3
Period:	September 1991–September 1995
Funding:	$ 2,454,232
Award:	Grant
Principal Investigator:	Mary Huntley
Awardee:	West Virginia Bureau of Public Health Office of Community and Rural Health Services 1411 Virginia Street, East Charleston, WV 25301
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, the establishment of rural health networks, and the regionalization and integration of services. The EACH/RPCH program consists of: a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services; and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1994, HCFA has awarded a total of $21.7 million in grant funds to these States and 96 hospitals within these States for program planning and participation. Regulations governing program operations (42 CFR Part 400 *et al.*) were published in the *Federal Register* and became effective June 25, 1993.

Status: The State of West Virginia is one of seven States participating in the EACH/RPCH program. Since 1991, the West Virginia Office of Community and Rural Health Services and 12 hospitals within the State have received funding to assist in program planning, development, and implementation.

93-074 Evaluation of Clinical and Educational Services to Rural Hospitals via Fiber Optic Cable

Project No.:	18-C-90254/7
Period:	September 1993–September 1995
Funding:	$ 698,322
Award:	Cooperative Agreement
Principal Investigator:	David S. Ramsey
Awardee:	Iowa Methodist Health System 1200 Pleasant Street Des Moines, IA 50309
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: This project will allow the Health Care Financing Administration to evaluate the effectiveness of a telemedicine system linking hospitals to an existing statewide fiber optic communications network. The Iowa Methodist Medical Center will be linked to both Greene County Medical Center and Trinity Regional Hospital. Project services include telemedicine (e.g., radiology, cardiology, and pathology consultations), education, and information systems components. Because of the limited sample size, the evaluation will focus on input and process indicators as opposed to outcome indicators.

Status: The first telemedicine services were provided in April 1994. The evaluation design is being finalized.

90-006 Evaluation of the Cost Effectiveness of Medicare Coverage of Influenza Vaccine

Project No.:	500-89-0049
Period:	October 1989–December 1994
Funding:	$ 3,062,471
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Edward T. Hutton, Ph.D. Division of Health Systems and Special Studies
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The objective of this project is to evaluate the cost effectiveness of furnishing influenza vaccinations to Medicare Part B beneficiaries as a Medicare-covered benefit. The demonstration included intervention and comparison areas in 10 sites and 10 statewide vaccine projects. In the former paired sites, bulk purchased vaccine was distributed to providers, intensive beneficiary and provider motivation campaigns were undertaken, private providers were paid $8 per dose to administer the vaccine (clinics were paid $4), and a dedicated carrier processed the claims. In the statewide sites, an influenza vaccination was treated as a covered benefit, and the local carrier paid providers for the cost of the vaccine and its administration. For the evaluation, the awardee is measuring the cost of the immunization benefit relative to the reduction in pneumonia and influenza hospitalization admissions (attributable to vaccine use) during the influenza season. The vaccine's effectiveness in preventing pneumonia and influenza hospital admissions was estimated through case control studies included in the demonstration. A national panel of experts assisted the Health Care Financing Administration, the Centers for

Disease Control and Prevention, and the awardee in conducting the demonstration and evaluation.

Status: Effective May 1, 1993, following the Report to Congress on April 26 from Secretary Shalala, Medicare began paying for influenza vaccinations. As permitted by Congress through section 4071 of Public Law 100-203, this service adds to the package of prevention services that Medicare already covers, which includes hepatitis B vaccines, pneumococcal pneumonia vaccines, mammograms, and pap smears. Measures of vaccine effectiveness during the defined influenza circulation period of severe influenza season were estimated to range from 32 to 45 percent. This range, which includes estimates from two severe seasons and four studies, may be viewed as low because of possible misclassification of cases since a confirmatory lab test for a preceding influenza illness was not possible. Overall survey vaccination rates for the fourth year of the demonstration (1991–92) were determined to be 59 and 46 percent, respectively, in the intervention and comparison areas. Influenza vaccination levels in 4 of 10 intervention sites exceeded the national health objective for the year 2000 of 60 percent vaccine coverage among noninstitutionalized persons aged ≥65 years, and overall vaccination levels in the demonstration (59 percent) nearly reached this objective. Taking into account the 2 point differential in vaccination rates in intervention and comparison areas that was observed at baseline, the demonstration is inferred to have increased vaccine coverage by 11 points. Vaccine coverage was increased through a variety of activities to promote and distribute vaccines to Medicare beneficiaries. These activities included Medicare paying for the administration and bulk purchase of the vaccine, informational letters sent to beneficiaries living in the demonstration areas, and motivational techniques to make influenza vaccination a routine practice in provider offices. The awardee is completing a national and demonstration followup survey of vaccine coverage during the 1993–94 influenza season among Medicare beneficiaries. The survey results will be available at the end of the contract, which has been extended until December 31, 1994. The final report is being prepared. Published information from the Medicare Influenza Vaccine Demonstration includes:

- Hannoun, C., Ruben, F., Klenk, H., et. al., ed: *Options for the Control of Influenza II: Proceedings of the International Conference on Options for the Control of Influenza, Courchevel, 27 September-2 October, 1992.* Elsevier Science Publishers B.V., Amsterdam, p. 468, 1993.
- Centers for Disease Control: *26th National Immunization Conference Proceedings.* Atlanta, p. 214, 1993.
- Centers for Disease Control: *27th National Immunization Conference Proceedings.* Atlanta, p. 214, in press.
- Centers for Disease Control: Final results: Medicare influenza vaccine demonstration—selected states, 1988–1992. *MMWR* 42(31):601-604, 1993.

91-078 Evaluation of the Essential Access Community Hospital/Rural Primary Care Hospital Program

(Formerly, Evaluation of the Essential Access Community Hospital Program)

Project No.:	500-87-0028TO16
Period:	September 1991–January 1995
Funding:	$ 697,764
Award:	Technical Support: Evaluation of Demonstrations (See page 216)
Principal Investigator:	George E. Wright, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Sheldon D. Weisgrau Division of Hospital Experimentation
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, the establishment of rural health networks, and the regionalization and integration of services. The EACH/RPCH program consists of: a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services; and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1994, HCFA has awarded $21.7 million in grant funds to these States and 96 hospitals within these States for program planning and participation.

Regulations governing program operations (42 CFR Part 400 *et al.*) were published in the *Federal Register* and became effective June 25, 1993. HCFA has contracted with Mathematica Policy Research (MPR) to conduct an evaluation of the planning and development phase of the EACH/RPCH program. The evaluation examines program development and implementation and the use of grant funds. This project also includes an analysis of the operations of facilities participating in the Montana Medical Assistance Facility Demonstration, a forerunner of the EACH program.

Status: MPR has collected program information through site visits, monitoring reports, interviews with program participants, and collection and analysis of data from the Federal, State, community, and facility levels. Preliminary evaluation findings indicate that the seven EACH/RPCH program States are taking different approaches to program implementation, ranging from regulatory to community-based models. The study indicates that program flexibility is needed to address local issues and that linkage of primary care services to the networks is essential. Participating facilities expect the program to be most useful in assisting hospitals to remain open and in improving emergency transportation services. The EACH/RPCH program also has been a catalyst for broad network development efforts within the participating States. A final evaluation report is expected in January 1995.

93-002 Expanded Cross-Cutting Evaluation of Medicare Prevention Demonstrations under the Consolidated Omnibus Budget Reconciliation Act

Project No.:	500-92-0057
Period:	October 1992–March 1995
Funding:	$ 357,699
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates Inc. (See page 216)
HCFA Project Officer:	Deborah C. Van Hoven Division of Health Systems and Special Studies
Mandates:	Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Abt Associates is conducting a cross-cutting evaluation of the five Medicare prevention demonstrations, mandated by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, which test the effectiveness of providing disease prevention and health promotion services to Medicare beneficiaries. Congress stipulated that the preventive health service package to be made available was to include health screenings, health risk appraisals, immunizations, and counseling and instruction in: diet and nutrition, reduction of stress, exercise programs, sleep regulation, injury prevention, prevention of substance abuse and mental disorders, self-care (including medication use), and smoking cessation.

Status: The contract for a cross-cutting evaluation was initially awarded September 30, 1987, and in May 1988, cooperative agreements were awarded to five schools of public health to implement the demonstration. Services under waivers began in May 1989 and ended in April 1991. The first Report to Congress (RTC) was submitted in April 1989. The COBRA 1985 legislation mandated 4-year demonstrations; the Omnibus Budget Reconciliation Act (OBRA) of 1990 extended them to 5 years. The OBRA 1990 extension allowed for an additional year of followup for purposes of evaluation and added two RTCs, due April 1993 and April 1995. The original evaluation contract was modified in October 1992, as a result of the OBRA 1990 extension. The second RTC was submitted in September 1993. The awardee is currently compiling information from the individual final reports submitted by the five sites. This will serve as the basis for the final cross-cutting RTC, due to Congress in April 1995.

94-103 Medicare End Stage Renal Disease Capitation Demonstration

Project No.:	500-94-0043DO02
Period:	September 1994–September 1997
Funding:	$ 499,444
Award:	Delivery Order in Master Contract
Principal Investigator:	Stanley Wallack, Ph.D.
Awardee:	Brandeis University (See page 207)
HCFA Project Officer:	Edward T. Hutton, Ph.D. Division of Health Systems and Special Studies

Description: The Omnibus Budget Reconciliation Act of 1993 extended the Social Health Maintenance Organization (S/HMO) demonstration and provided for additional sites, which included a site providing services to Medicare end stage renal disease (ESRD) beneficiaries under a capitated payment system. The purpose of this

contract is to assist the Health Care Financing Administration (HCFA) in developing, implementing, and monitoring a demonstration to provide health services to Medicare ESRD beneficiaries under a capitated payment plan. Also, because this demonstration is congressionally mandated and requires a Report to Congress (RTC), the awardee will be responsible for providing information to the Office of Research and Demonstrations for preparing the interim RTC. Under the demonstration, HCFA would provide an all-inclusive capitation payment for all Medicare-covered Part A and Part B acute and chronic care services. HCFA's intent in providing a capitated payment is to promote efficiency and quality in health service delivery to Medicare ESRD beneficiaries. It is expected that a capitated payment system will facilitate flexibility in managing the beneficiaries' medical care and will reduce Medicare's administrative costs and lessen the burden to the Medicare program, physicians, and beneficiaries. The Medicare ESRD Capitation Demonstration, which is being planned for a single site, may include benefits appropriate under the S/HMO concept. Services will be provided for 3 years, beginning January 1996. A separate procurement action will award a contract to evaluate the demonstration. The evaluation shall assess the quality of care and health outcomes of ESRD patients under a capitated payment system, as well as evaluate the cost effectiveness and cost benefit of a Medicare ESRD capitated payment system.

Status: This project is in the early developmental phase.

88-007 Medicare Prevention Demonstration under the Consolidated Omnibus Budget Reconciliation Act: The Johns Hopkins University

Project No.:	95-C-99162/3
Period:	May 1988–July 1994
Funding:	$ 1,914,284
Award:	Cooperative Agreement
Principal Investigator:	Pearl S. German, Sc.D.
Awardee:	The Johns Hopkins University School of Hygiene and Public Health 624 North Broadway Baltimore, MD 21205
HCFA Project Officer:	Sherrie L. Fried Division of Health Systems and Special Studies
Mandates:	Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The Johns Hopkins University provided preventive services to a representative population of Medicare beneficiaries residing in the eastern third of Baltimore City and in small areas of Baltimore County. After a baseline interview covering areas of health status, risk, and sociodemographics, the population was randomly assigned to either an intervention or control group. Preventive services screening and intervention were performed by the beneficiary's own physician. The University is conducting a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Status: The demonstration began offering preventive services in May 1989, and services ended in April 1991. Section 4164(a)(1) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 extended the demonstration and increased the $5.9 million limit for administrative and evaluation costs to $10.5 million to allow the projects to follow participants and measure the long-term outcomes of the preventive services. The legislation requires an interim Report to Congress (RTC) in April 1993 and a final RTC in April 1995. To prepare the final RTC and comply with OBRA 1990, the demonstration was extended for an additional 2-year period, through April 30, 1994. The project was given a no-cost extension through July 31, 1994. A draft final report was submitted in June 1994. After comments from the Health Care Financing Administration, the project is currently preparing its final report. Results from this report will be incorporated in the final cross-cutting RTC in April 1995.

88-006 Medicare Prevention Demonstration under the Consolidated Omnibus Budget Reconciliation Act: San Diego State University

Project No.:	95-C-99160/9
Period:	May 1988–July 1994
Funding:	$ 1,816,500
Award:	Cooperative Agreement
Principal Investigator:	Stephen J. Williams, Sc.D.
Awardee:	San Diego State University Foundation Graduate School of Public Health San Diego State University San Diego, CA 92182-1900
HCFA Project Officer:	Deborah C. Van Hoven Division of Health Systems and Special Studies

Mandates: Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Medicare beneficiaries who are currently enrolled in the Secure Horizons health maintenance organization (HMO) were targeted for preventive services. The sample size was originally expected to be 2,400; however, the HMO requested and received approval to reduce its sample size to 1,800, from which one-half were randomly assigned to the treatment group and one-half to the control group. The San Diego School of Public Health is conducting a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Status: Preventive services were initiated in May 1989 and ended in April 1991. Section 4164(a)(1) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 extended the demonstration and increased the funding for administrative and evaluation costs to allow the projects to follow participants and measure the long-term outcomes of the preventive services. The legislation requires an interim Report to Congress (RTC) in April 1993 and a final RTC in April 1995. To prepare the final RTC and comply with OBRA 1990, the demonstration was extended for an additional 2-year period, through April 30, 1994. The project was given a no-cost extension through July 31, 1994. A draft final report was submitted. After comments from the Health Care Financing Administration, the project is currently preparing its final report. Results from this report will be incorporated in the final cross-cutting RTC in April 1995.

88-008 Medicare Prevention Demonstration under the Consolidated Omnibus Budget Reconciliation Act: University of California, Los Angeles

Project No.:	95-C-99165/9
Period:	May 1988–July 1994
Funding:	$ 1,936,200
Award:	Cooperative Agreement
Principal Investigator:	Stuart O. Schweitzer, Ph.D.
Awardee:	University of California School of Public Health 10833 Le Conte Avenue Los Angeles, CA 90024-1772
HCFA Project Officer:	Deborah C. Van Hoven Division of Health Systems and Special Studies

Mandates: Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Medicare beneficiaries who are current patients of the University of California, Los Angeles (UCLA) university-based clinic were targeted for preventive and dental referral services. Approximately 1,930 participants were randomly assigned to treatment or control groups. UCLA is conducting a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Status: Preventive services were initiated in May 1989 and ended in April 1991. Section 4164(a)(1) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 extended the demonstration and increased the funding for administrative and evaluation costs to allow the projects to follow participants and measure the long-term outcomes of the preventive services. The legislation requires an interim Report to Congress (RTC) in April 1993 and a final RTC in April 1995. To prepare the final RTC and comply with OBRA 1990, the demonstration was extended for an additional 2-year period, through April 30, 1994. The project was given a no-cost extension through July 31, 1994. A final report was submitted in June 1994. Results from this report will be incorporated in the final cross-cutting RTC in April 1995.

88-009 Medicare Prevention Demonstration under the Consolidated Omnibus Budget Reconciliation Act: University of Pittsburgh

Project No.:	95-C-99159/4
Period:	May 1988–July 1994
Funding:	$ 1,812,559
Award:	Cooperative Agreement
Principal Investigator:	Lewis H. Kuller, M.D.
Awardee:	University of Pittsburgh Department of Epidemiology 130 Desoto Street Pittsburgh, PA 15261
HCFA Project Officer:	Sherrie L. Fried Division of Health Systems and Special Studies

Mandates: Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The demonstration provided preventive services to Medicare beneficiaries residing in rural counties in western Pennsylvania. More than 3,880 demonstration participants received health risk appraisals and were randomly assigned to two treatment groups and one control group. The treatment groups included beneficiaries receiving services at clinics and physician offices. The University of Pittsburgh is conducting a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Status: The demonstration began offering preventive services in May 1989, and services ended in April 1991. Section 4164(a)(1) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 extended the demonstration and increased the funding for administrative and evaluation costs to allow the projects to follow participants and measure the long-term outcomes of the preventive services. The legislation requires an interim Report to Congress (RTC) in April 1993 and a final RTC in April 1995. To prepare the final RTC and comply with OBRA 1990, the demonstration was extended for an additional 2-year period, through April 30, 1994. The project was given a no-cost extension through July 31, 1994. A draft final report was submitted. After comments from the Health Care Financing Administration, the project is currently preparing its final report. Results from this report will be incorporated in the final cross-cutting RTC in April 1995.

88-010 Medicare Prevention Demonstration under the Consolidated Omnibus Budget Reconciliation Act: University of Washington

Project No.: 95-C-99161/0
Period: May 1988–July 1994
Funding: $ 1,896,422
Award: Cooperative Agreement
Principal Investigator: Donald L. Patrick, Ph.D.
Awardee: University of Washington
School of Public Health and Community Medicine
F346 Health Sciences Building SC37
Seattle, WA 98195

HCFA Project Officer: Sherrie L. Fried
Division of Health Systems and Special Studies

Mandates: Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The University of Washington implemented a randomized design to assess the cost savings and changes in health-related quality of life associated with providing a preventive service package (annual health risk assessment, individual health promotion, and group counseling) for Medicare beneficiaries enrolled in Group Health Cooperative (GHC) of Puget Sound. The project took place in Seattle, Washington, at four GHC medical centers.

Status: GHC began offering preventive services in May 1989, and services ended in April 1991. Section 4164(a)(1) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 extended the demonstration and increased the funding for administrative and evaluation costs to allow the projects to follow participants and measure the long-term outcomes of the preventive services. The legislation requires an interim Report to Congress (RTC) in April 1993 and a final RTC in April 1995. To prepare the final RTC and comply with OBRA 1990, the demonstration was extended for an additional 2-year period, through April 30, 1994. The project was given a no-cost extension through July 31, 1994. A final report was submitted in June 1994. Results from this report will be incorporated in the final cross-cutting RTC in April 1995.

94-066 Midwest Rural Telemedicine Consortium: A Pilot Demonstration Project

Project No.: 95-C-90425/7
Period: July 1994–July 1997
Funding: $ 1,777,831
Award: Cooperative Agreement
Principal Investigator: John A. Kolosky
Awardee: Mercy Foundation
Sixth and University
Des Moines, IA 50314
HCFA Project Officer: Cynthia K. Mason
Division of Hospital Experimentation

Description: The project will evaluate the medical effectiveness, patient and provider acceptance, and costs

associated with telemedicine services as well as their impact on access to care in rural areas. The demonstration will involve six rural hospitals (Audubon County Memorial Hospital, Franklin General Hospital, Hamilton County Public Hospital, Kossuth County Hospital, St. Joseph Community Hospital, and St. Joseph's Mercy Hospital); one rural referral hospital (North Iowa Mercy Health Center); and one urban hospital (Mercy Hospital Medical Center). Proposed services include interactive video consultations supported by teleradiology, telepathology, and where available, telesonography, electrocardiography, and fetal monitoring strips. Payment for related physician services will be made pursuant to a waiver of Medicare payment regulations. The goal of the project is to evaluate whether specialty telemedical services provided by hospital networks produce change with respect to medical effectiveness, patient and provider satisfaction, cost, and access. Hypotheses include: telemedicine improves differential diagnoses and treatment; patients and providers are as satisfied with telemedicine as with onsite services; telemedicine services are less costly than are onsite services; and telemedicine improves access to a wider range of health care services.

Status: This project is in the early developmental stage.

94-064 Rural Telemedicine Demonstration Grant

Project No.:	95-C-90367/4
Period:	July 1994–July 1997
Funding:	$ 271,514
Award:	Cooperative Agreement
Principal Investigator:	Diane M. Jacobs
Awardee:	East Carolina University Greenville, NC 27858
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: The proposed research methodology will develop case studies and hard data describing the impact and quality of medical care in remote areas. Other items to be studied include utilization rates and cost structure, types of services appropriate to telemedicine, diagnostic effectiveness, and payment methodology. The demonstration will test a system of Medicare payments for telemedicine services involving two rural North Carolina hospitals, Roanoke-Chowan Hospital and Martin General Hospital, interacting with the regional medical center and medical school affiliate, Pitt County Memorial Hospital, to deliver primary care services. This project has eight objectives: to evaluate the impact of telemedicine on access to care; to determine specialty services appropriate for rural telemedicine; to determine whether the type of health care provider presenting the patient to the consultant affects the quality and clinical value of the consultation; to evaluate the educational value of the telemedicine consultation; to develop a prototype for delivery of telemedicine services; to determine if the diagnostic effectiveness for dermatological examinations can be maintained via telecommunications; to evaluate the costs of providing telemedicine services (direct, indirect, and ancillary); and to examine the impact of payment for telemedicine services on the actual consultation and on the broader health care delivery system.

Status: This project is in the early developmental stage.

94-123 State-Administered Programs for Human Immunodeficiency Virus-Related Care

Project No.:	18-P-90286/5
Period:	September 1994–August 1996
Funding:	$ 56,133
Award:	Grant
Principal Investigator:	Robert J. Buchanan, Ph.D.
Awardee:	Board of Trustees of the University of Illinois Department of Community Health 109 Coble Hall 801 South Wright Street Champaign, IL 61820
HCFA Project Officer:	Michael Kendix, Ph.D. Division of Beneficiary Studies

Description: The study describes, catalogues, and analyzes a range of State-administered public programs that cover and finance the health care needs of persons with acquired immunodeficiency syndrome (AIDS) and persons who are infected with the human immunodeficiency virus (HIV). The study focuses on: Title II programs of the Ryan White CARE Act; State-funded, medical assistance programs; and Medicaid 2176 home and community-based waivers. It also focuses on the action of the State health departments that address the increasing incidence of tuberculosis, especially among persons with AIDS and people who are HIV positive; and the coordination of eligibility for these State-administered programs with the Medicaid program of each State. This project also investigates the assessments the administrators of each State's AIDS office, as well as the administrators of voluntary AIDS organizations at the State and local levels, have about how well each of these State-administered programs (including Medicaid) addresses the health care needs of

people with AIDS and people infected with HIV, closing any holes in the Medicaid safety net.

Status: This project is in the early developmental stage.

94-129 Sustainable Support System for Telemedicine Research and Evaluation

Project No.:	18-C-90413/0
Period:	September 1994–March 1996
Funding:	$ 246,296
Award:	Cooperative Agreement
Principal Investigator:	Douglas A. Perednia
Awardee:	Telemedicine Research Center 7276 SW. Beaverton-Hillsdale Highway Suite 187 Portland, OR 97225
HCFA Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: The primary goal of this project is to create an effective, ongoing mechanism by which the cost, effectiveness, and utility of telemedicine services can be systematically evaluated. This will be done through the formation of a Clinical Telemedicine Cooperative Group (CTCG). The CTCG will be based at the Telemedicine Research Center, a non-profit public service research corporation in Portland, Oregon, that has been formed to foster high-quality research in telemedicine. The CTCG will be modeled after a successful cooperative multicentered research organization. Functions of the CTCG will include: providing operational and statistical support for telemedicine research and evaluation; maintaining a communication system for linking geographically distant telemedicine projects for the purpose of sharing information and performing telemedicine research; creating easily adaptable, electronic data collection and tabulation instruments for use in telemedicine research studies; and building a comprehensive online telemedicine information clearing house for gathering, storing, and disseminating information about the utility, effectiveness, and suitability of telemedicine for a broad range of medical and social applications.

Status: This project is in the early developmental stage. Data collection will be initiated at the Mercy Foundation and the Iowa Methodist Health System in Des Moines, Iowa, as well as at East Carolina University in Greenville, North Carolina.

93-026 Virtual Interactive Rehabilitation via Remote Computer

Project Nos.:	97-P-08040/0-01 (Phase I) 97-P-08040/0-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 34,930 (Phase I) $ 117,958 (Phase II)
Award:	Grant
Principal Investigator:	Howard Davis, Ph.D.
Awardee:	ScienTech, Inc. SE. 1122 Latah Street Pullman, WA 99163
HCFA Project Officer:	Michael J. Baier Office of Operations Support
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The primary objective of this project is to test the feasibility of linking physical rehabilitation patients to remote caregivers by means of a novel high-performance data analysis and communications system. The system involves computer-driven rehabilitation equipment and advanced telecommunications designed to bring the therapist into the home.

Status: This project is in Phase II (testing and data gathering). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

Subacute and Long-Term Care

94-086 Acute and Long-Term Care: Use, Costs, and Consequences

Project No.:	17-C-90323/3
Period:	September 1994–August 1997
Funding:	$ 595,787
Award:	Cooperative Agreement
Principal Investigator:	Korbin Liu, Ph.D.

Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Carolyn Rimes Division of Long-Term Care Experimentation

Description: This study will provide current information that will aid policymakers in developing options to better integrate acute, subacute, and long-term care services. Data from the Medicare Current Beneficiary Survey will be used to address three issues: transitions among acute, subacute, and long-term care; "catastrophic" costs resulting from the use of those services; and interactions between Medicare and Medicaid home health care. The transitions analysis is designed to measure differences in the patterns of acute, subacute, and long-term care use by the characteristics of Medicare beneficiaries, and to determine potential areas of access or quality of care problems. The costs analysis is designed to assess the cumulative risks over 3 years of incurring "catastrophic" health care costs or experiencing Medicaid spend-down. The effects of the Qualified Medicare Beneficiaries program will be evaluated. The home health care analysis is designed to estimate the interactions, and possible overlaps between two rapidly expanding public programs that finance similar services. The relationship between home health care use and costs, and the personal characteristics of Medicare beneficiaries and the characteristics of geographic areas, including Medicaid policies, will be examined.

Status: This project is in the developmental phase.

94-047 Analysis of Choice Processes in Capitated Plan Enrollment: Statistical Models for Evaluation of Voluntary Enrollment to Long-Term Care Demonstration Projects

Project No.:	500-89-0047/45
Period:	January 1994–May 1994
Funding:	$ 217,800
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The purpose of this study is to update/refine previous work (done by Kenneth Manton of Duke University) on the factors affecting a person's decision to enroll in managed care plans. This study is comprised of five tasks:

- Task A. Evaluate Health Care Financing Administration cost reports to determine if conclusions previously made about social health maintenance organization (S/HMO) expenditures (which were obtained using the management information files obtained from each S/HMO site) are affected.
- Task B. Conduct outcome analyses for each of the four sites.
- Task C. Estimate cost regressions using the two-stage regression procedure.
- Task D. Conduct an outcome analysis using Cox regression.
- Task E. Conduct choice modeling.

Lewin/VHI's subcontractor, Kenneth Manton, is the lead analyst.

Status: Analyses of Tasks A-D have been completed and a draft report is under review.

92-092 Analysis of Informal and Formal Care (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/35
Period:	June 1992–December 1995
Funding:	$ 93,700
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The purpose of this study is to determine whether formal care substitutes (or complements) informal care. To determine the relationship between formal care and informal care, a data set generated by the case management agency Connecticut Community Care, Inc. (CCCI), is analyzed. CCCI conducts patient assessments of all publicly supported long-term care patients in Connecticut. This data set offers a unique opportunity to conduct an indepth longitudinal analysis of the effect of providing formal care on the provision of informal care for a large population of elderly persons. Although surveys have repeatedly found that older persons strongly prefer community services to services offered in nursing homes, policymakers have resisted a major expansion of home care services even though community services are usually less expensive than are services offered in nursing homes. Perhaps the most

important reason for this resistance is the fear that a publicly funded home care program will encourage family caregivers of the elderly to substitute formal care for informal care. This work will be performed by Sharon Long of The Urban Institute, a subcontractor to Lewin/VHI, Inc.

Status: This project will be completed by December 1994.

92-093 **Analysis of Nonparticipation in the 2176 Program** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/34
Period:	June 1992–November 1994
Funding:	$ 132,400
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: In recent years a major focus of research on home and community-based care (HCBC) has been on the number of persons who would be eligible for services on dependencies in activities of daily living (ADL). While previous researchers have estimated the size of beneficiary populations under different eligibility standards, little is known about the number of eligibles who would actually participate in HCBC programs. This project examines why 20 percent of persons meeting ADL requirements for eligibility did not participate in the Medicaid 2176 program in Connecticut. The subsequent use of long-term care services by these nonparticipants is compared to the use of services by participants in the Connecticut Medicaid 2176 program. Lewin/VHI's subcontractor, Korbin Liu of The Urban Institute, is the lead analyst.

Status: This project will be completed in November 1994.

92-094 **Analysis of Nursing Home Payment with Current Beneficiary Survey Data** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/32
Period:	May 1992–December 1994
Funding:	$ 55,500
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: Although national estimates of nursing home expenditures have been derived from various data bases, direct estimates of the distribution of nursing home patients by the amount of payment and by the source of payment have not been derived. This study is the first attempt to utilize a major source of new information on nursing home payment, the Medicare Current Beneficiary Survey, to estimate these distributions. The Current Beneficiary Survey is a 1-year panel data set that provides detailed information on payment sources and amounts paid by each source for a nationally representative sample of aged Medicare nursing home patients. This work has been subcontracted to Korbin Liu of The Urban Institute.

Status: This project will be completed by December 1994.

94-046 **Analysis of Post-Acute Care and Therapy Services Using the Health Care Financing Administration Episode Data Base**

Project No.:	500-89-0047/46
Period:	August 1994–April 1995
Funding:	$ 138,300
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: This two-part study uses the Health Care Financing Administration (HCFA) Episode Data Base to:

- Update earlier research on post-hospital care and rehabilitation following hospital admissions with more recent data.
- Examine trends in use over time by comparing the 1992 findings to several RAND analyses and a Lewin/VHI analysis on therapy services conducted for the American Association for Retired Persons.
- Analyze the use of rehabilitation/therapy services across settings.

- Contribute to the discussion of policy and payment implications of increased use of post-acute services.

This analysis is being conducted in collaboration with HCFA analysts, William Buczko and Judith Sangl.

Status: Tabulations on rehabilitation are under way. A draft report will be submitted in November 1994. The post-acute analysis is expected in April 1995.

92-097 **Analysis of Transitions in the Characteristics of the Long-Term Care Population** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/11
Period:	December 1991–November 1994
Funding:	$ 63,900
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: This study analyzes possible changes in future Medicare expenditures under two types of interventions: promotion of health and functioning, and substitution of special equipment and assistive devices for personal assistance. Utilizing the 1982, 1984, and 1989 linked National Long-Term Care Survey, this research focuses on the longitudinal changes in health and functioning; institutional risks; and Mortality risks for elderly persons with a given impairment level. After identifying the conditions associated with the most amount of impairment, the investigators will examine how reducing the incidence and severity of particular medical conditions can: reduce the duration and level of impairment, and reduce costs, especially for public programs such as Medicare and Medicaid. Lewin/VHI's subcontractor, Kenneth Manton of Duke University, is the lead analyst.

Status: The draft final report will be completed in October 1994.

93-089 **Case Studies of Medicaid Estate Planning** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/39
Period:	April 1993–December 1994
Funding:	$ 200,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: There are two major purposes for these case studies. The first is to provide an indepth descriptive analyses of State policy responses to Medicaid estate planning, including the effectiveness of estate recovery programs. The second is to provide a methodology for conducting quantitative empirical studies that measure the extent of Medicaid estate planning activity and the relative cost effectiveness of alternative State policy responses. The data used were obtained from Medicaid eligibility offices in Connecticut, Florida, California, and New York. This project will be completed by Brian Burwell of SysteMetrics, A MEDSTAT® Division, under subcontract to Lewin/VHI, Inc.

Status: This project is targeted for completion in December 1994.

92-098 **Catastrophic Costs of Long-Term Care** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/12
Period:	December 1991–November 1994
Funding:	$ 50,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: This study utilizes the Brookings/Intermediate Care Facility Long-Term Care Financing Model to examine both current and future financial burdens associated with long-term care costs. Lewin/VHI's subcontractor, Joshua Wiener of The Brookings Institution, is the lead analyst.

Status: A draft report has been submitted to the Office of Research and Demonstrations. The final report is expected by the end of 1994.

93-090 **Catastrophic Costs and Medicaid Spenddown** (Formerly Long-Term Case Studies (Section 207))

Project No.:	500-89-0047/37
Period:	January 1993–May 1995
Funding:	$ 180,300
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: This study uses data from the Medicare Current Beneficiary Survey to analyze the occurrence of catastrophic costs among the elderly resulting from Medicaid spenddown. The purpose of this study is to support the formulation of policy for health care reform for the elderly. Consequently, this study categorizes the causes of out-of-pocket costs for different types of acute and long-term care services that may create financial hardships and identifies which subgroups of the elderly are likely to incur catastrophic costs. This work will be completed by Korbin Liu of The Urban Institute under subcontract to Lewin/VHI, Inc.

Status: Preliminary analyses will be completed by October 1994. The final report will be submitted in May 1995.

94-083 **Changing Roles of Nursing Homes**

Project No.:	17-C-90428/5
Period:	September 1994–September 1997
Funding:	$ 831,182
Award:	Cooperative Agreement
Principal Investigator:	Brant Fries, Ph.D.
Awardee:	Institute of Gerontology University of Michigan 300 North Ingalls Building, Room 900 Ann Arbor, MI 48109-2007
HCFA Project Officer:	Ellen O'Brien Division of Long-Term Care Experimentation

Description: Over the past two decades, the role of nursing homes in caring for the elderly and disabled has changed. While considered primarily custodial in the mid-1970s, nursing homes are increasingly caring for populations requiring more special and rehabilitative care, and this role is likely to increase in the future. This study will examine two special populations in nursing homes: the chronically mentally ill (beyond those with dementia) and hospice terminal-care residents. A large sample of resident assessments collected on nursing home residents in several States is to be assembled and linked to Federal data sets such as the Online Survey and Certification Reports, the area resource file, and Medicare Part A and Part B claims files to answer the research questions. The assessment tool, the Minimum Data Set for Nursing Home Resident Assessment and Care Screening, currently is used to collect health status data on all nursing home residents in Medicaid- and Medicare-certified nursing facilities. Several quality, utilization, and cost issues will be examined. It is hypothesized, for example, that residents with chronic mental illness are more likely than are other similarly impaired residents to be chemically restrained, to experience increasing functional impairment, and to have increased behavior problems. Consequently, it also is hypothesized that the chronically mentally impaired have greater overall utilization of Medicare services than do non-mentally impaired residents with similar levels of functional impairment. With regard to the population of hospice users, it is hypothesized that these residents should have a lower rate of rehospitalization than do nonhospice nursing home residents with similar medical conditions. The secondary data analysis will permit an analysis of these special populations and will provide policy-relevant information to the Health Care Financing Administration on future directions for nursing homes.

Status: This project is in the early developmental stage.

92-070 **Community Nursing Organization Demonstration: Carle Clinic Association** (Formerly, Community Nursing Organization Demonstration)

Project No.:	500-92-0053
Period:	September 1992–December 1996
Funding:	$ 1,786,629
Award:	Contract
Principal Investigator:	Cheryl Schraeder, Ph.D.
Awardee:	Carle Clinic Association 307 East Oak, Suite 3 P.O. Box 718 Mahomet, IL 61853
HCFA Project Officer:	Barbara Greenberg, Ph.D. Division of Long-Term Care Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: Section 4079 of Public Law 100-203 directs the Secretary of Health and Human Services to conduct demonstration projects at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the Community Nursing Organization (CNO) Demonstration are capitated payment and nurse case management. These two elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. Four applicants were awarded site demonstration contracts on September 30, 1992. The selected sites represent a mix of urban and rural sites and different types of health providers including a home health agency (HHA), a hospital-based system, and a large multispecialty clinic. The four sites are:

- Carle Clinic Association, Mahomet, Illinois, one of the largest multispecialty physician group practices in the United States, serves as the regional medical center for the rural population that resides in Central Illinois and Western Indiana and serves nearly 2,000 patients daily.
- Carondolet Health Services, Inc., Tucson, Arizona, a group of three hospitals, a family center, and 17 community health centers, is sponsored by the Sisters of St. Joseph of Carondelet.
- Visiting Nurse Service of New York, New York, is the largest nonprofit Medicare-certified HHA in the United States.
- Living at Home/Block Nurse Program, St. Paul, Minnesota, is a nursing organization dedicated to assisting communities in replicating the Living at Home/Block Nurse Program model of local volunteer and nursing support for the elderly.

Status: All four CNO Demonstration sites have undergone a 1-year developmental period and began a 3-year operational period in January 1994.

92-071 **Community Nursing Organization Demonstration: Carondelet Health Services, Inc.**
(Formerly, Community Nursing Organization Demonstration)

Project No.:	500-92-0055
Period:	September 1992–September 1996
Funding:	$ 387,820
Award:	Contract
Principal Investigator:	Gerri Lamb, Ph.D.
Awardee:	Carondelet Health Services, Inc. Carondelet St. Mary's Hospital 1601 West St. Mary's Road Tucson, AZ 85745
HCFA Project Officer:	Melissa McNiff Division of Long-Term Care Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The purpose of the Community Nursing Organization (CNO) Demonstration is to develop and evaluate a nurse case-managed health care delivery system that provides Medicare-covered home health services, ambulatory care services, and durable medical equipment to eligible beneficiaries. Section 4079 of Public Law 100-203 directed the Secretary of Health and Human Services to conduct this demonstration at four or more sites. The authorizing legislation identified a package of mandatory services that each CNO has to provide. It also required that the demonstration have a capitated payment method modeled after the average adjusted per capita cost payment used with health maintenance organizations. Another provision of the legislation stipulated that an alternative capitation formula be implemented in at least one of the four sites. The participating organizations will assume full financial risk for the demonstration's mandatory service package. In addition to these services, Carondelet provides optional services such as homemaker/home health aide services and respite care. The project's evaluation will examine the feasibility and viability of a capitated nurse-coordinated service model.

Status: On September 30, 1992, Carondelet Health Services was awarded one of four contracts to conduct the CNO Demonstration. During the project's developmental year, the Carondelet Health Services established its organizational protocol, marketing and enrollment plan, service delivery system, and data collection plan for implementation of the CNO Demonstration. The 3-year operational phase of the demonstration began in January 1994. Abt Associates Inc., was selected to evaluate the project and to provide technical assistance to the four CNO sites. Abt Associates also was awarded the external quality assurance contract.

94-038 **Community Nursing Organization Demonstration External Quality Assurance**

Project No.:	500-92-0014DO04
Period:	July 1994–July 1997
Funding:	$ 535,304

Award:	Delivery Order in Master Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates Inc. (See page 206)
HCFA Project Officer:	Melissa McNiff Division of Long-Term Care Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The purpose of the Community Nursing Organization (CNO) Demonstration External Quality Assurance project is to conduct an external review of the quality of health care delivered to Medicare beneficiaries participating in the CNO demonstration (a risk-reimbursed coordinated care program for home health and selected ambulatory services). The CNO Demonstration External Quality Assurance project includes a quarterly review of client medical records for a sample of clients receiving Medicare-covered mandatory CNO services, and a quarterly review of CNO assessments and provision of CNO interventions on a sample of all enrollees. Under this project, the awardee will be responsible for monitoring the quality of case management and health education services provided through the CNO and implementing corrective actions when necessary. The quality of traditional Medicare home health services will be monitored. The awardee also will conduct a utilization review of the home health services provided to enrollees to validate or support changes in capitation payment rates. The evaluation contractor will be provided with accurate and complete documentation of the findings and interventions of the quality assurance process.

Status: The developmental phase of the project has been completed and reviews will be conducted.

92-072 Community Nursing Organization Demonstration: Living at Home/Block Nurse Program

(Formerly, Community Nursing Organization Demonstration)

Project No.:	500-92-0052
Period:	September 1992–September 1996
Funding:	$ 193,938
Award:	Contract
Principal Investigator:	Linda Robertson
Awardee:	Living at Home/Block Nurse Program Ivy League Place, Suite 225 475 Cleveland Avenue North St. Paul, MN 55104
HCFA Project Officer:	Melissa McNiff Division of Long-Term Care Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The purpose of the Community Nursing Organization (CNO) Demonstration is to develop and evaluate a nurse case-managed health care delivery system that provides Medicare-covered home health services, ambulatory care services, and durable medical equipment to eligible beneficiaries. Section 4079 of Public Law 100-203 directed the Secretary of Health and Human Services to conduct this demonstration at four or more sites. The authorizing legislation identified a package of mandatory services that each CNO has to provide. It also required that the demonstration have a capitated payment method modeled after the average adjusted per capita cost payment used with health maintenance organizations. Another provision of the legislation stipulated that an alternative capitation formula be implemented in at least one of the four sites. The participating organizations will assume full financial risk for the demonstration's mandatory service package. In addition to these services, the Living at Home/Block Nurse Program provides optional services such as homemaker/home health aide services and respite care. The project's evaluation will examine the feasibility and viability of a capitated nurse-coordinated service model.

Status: On September 30, 1992, the Living at Home/Block Nurse Program was awarded one of four contracts to conduct the CNO Demonstration. During the project's developmental year, the Living at Home/Block Nurse Program established its organizational protocol, marketing and enrollment plan, service delivery system, and data collection plan for implementation of the CNO Demonstration. The 3-year operational phase of the demonstration began in January 1994. Abt Associates, Inc., was selected to evaluate the project and to provide technical assistance to the four CNO sites. Abt Associates also was awarded the external quality assurance contract.

92-073 **Community Nursing Organization Demonstration: Visiting Nurse Service of New York** (Formerly, Community Nursing Organization Demonstration

Project No.:	500-92-0054
Period:	September 1992-December 1996
Funding:	$ 945,281
Award:	Contract
Principal Investigator:	Ruth Mitchell
Awardee:	Visiting Nurse Service of New York 107 East 70th Street New York, NY 10021-5087
HCFA Project Officer:	Barbara Greenberg, Ph.D. Division of Long-Term Care Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: Section 4079 of Public Law 100-203 directs the Secretary of Health and Human Services to conduct demonstration projects at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the Community Nursing Organization (CNO) Demonstration are capitated payment and nurse case management. These two elements are designed to promote timely and appropriate use of community health services and reduce the use of costly acute care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. Four applicants were awarded site demonstration contracts on September 30, 1992. The selected sites represent a mix of urban and rural sites and different types of health providers including a home health agency (HHA), a hospital-based system, and a large multispecialty clinic. The four sites are:

- Visiting Nurse Service of New York, New York, is the largest nonprofit Medicare-certified HHA in the United States.
- Living at Home/Block Nurse Program, St. Paul, Minnesota, is a nursing organization dedicated to assisting communities in replicating the Living at Home/Block Nurse Program model of local volunteer and nursing support for the elderly.
- Carle Clinic Association, Mahomet, Illinois, one of the largest multispecialty physician group practices in the United States, serves as the regional medical center for the rural population that resides in Central Illinois and Western Indiana and serves nearly 2,000 patients daily.
- Carondolet Health Services, Inc., Tucson, Arizona, a group of three hospitals, a family center, and 17 community health centers, is sponsored by the Sisters of St. Joseph of Carondelet.

Status: All four CNO Demonstration sites have undergone a 1-year developmental period and began a 3-year operational period in January 1994.

93-077 **Community-Supported Living Arrangements Program: Process Evaluation**

Project No.:	500-92-0035DO02
Period:	September 1993–August 1996
Funding:	$ 411,941
Award:	Delivery Order in Master Contract
Principal Investigator:	Marilyn Ellwood
Awardee:	SysteMetrics/MedStat (See page 206)
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation
Mandate:	Section 4712 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The Community-Supported Living Arrangements (CSLA) Program is designed to test the effectiveness of developing, under section 1930 of the Social Security Act, a continuum of care concept as an alternative to the Medicaid-funded residential services provided to individuals with mental retardation and related conditions (MR/RC) as an optional State plan service. The CSLA program serves individuals with MR/RCs who are living in the community either independently, with their families, or in homes with three or fewer other individuals receiving CSLA services. This model of care includes personal assistance; training and habilitation services necessary to assist individuals in achieving increased integration, independence, and productivity; 24-hour emergency assistance; assistive technology; adaptive technology; support services necessary to aid these individuals in participating in community activities; and other services as approved by the Secretary of Health and Human Services. Costs related to room and board and to prevocational, vocational, and supported employment services are excluded from coverage. In accordance with the legislatively set maximum, California, Colorado, Florida, Illinois, Maryland, Michigan, Rhode Island, and Wisconsin, have implemented CSLA programs. The purpose of this contract is to provide an evaluation of the CSLA program to the Health Care Financing

Administration's Medicaid Bureau and Congress for their consideration of policy options regarding the continuation and/or expansion of the Medicaid State Plan optional service. The evaluation will address five areas:

- Philosophy or goals guiding States' CSLA programs.
- Description of CSLA programs with respect to recipients, types of services received, and the cost of such services.
- Description and discussion of quality assurance mechanisms being implemented.
- Exploration of the question of compatibility of the supported living concept with current goals and the structure of the Medicaid program.
- Exploration of the relationship between the supported living concept and the Americans with Disabilities Act.

A common data set is to be developed from the eight CSLA States.

Status: The contract was awarded on September 30, 1993. As of September 1994, five of the eight site visits to the participating States have been conducted. The final evaluation report is expected in February 1995.

93-091 **Consumer Protection and Private Long-Term Care Insurance** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/16
Period:	December 1992-December 1994
Funding:	$ 130,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: This study consists of a two-part analysis. The first is a policy-oriented synthesis of research conducted to date on long-term care (LTC) insurance. The purpose of this synthesis is to serve as a baseline of understanding for policymakers and to identify relevant issues at which future research should be directed. The second part focuses on regulatory issues. This part contains case studies of Arizona, California, Florida, Indiana, North Dakota, New York, Oregon, South Carolina, Texas, and Wisconsin that have passed legislation to regulate private LTC insurance and summarizes how insurance companies have responded to this regulation. This project will be carried out jointly by Lewin/VHI (Lisa Alecxih) and The Brookings Institution.

Status: The policy-oriented synthesis has been completed. This synthesis discusses the growth of the LTC insurance market from less than 50,000 policies in 1984 to nearly 3 million sold in 1992. Although this growth is significant, the market penetration is less than expected; approximately 5 percent of the elderly have LTC insurance, while 70 percent purchase Medicap policies. The paper reviews potential reasons for limited market penetration, including consumer confusion, barriers to coverage, marketing and sales abuses, concern over product value, and regulation. An analysis of the case studies is taking place and the draft report on regulatory issues will be completed in October 1994.

93-092 **Costs of Medicare Skilled Nursing Facility Therapy Services** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/41
Period:	July 1993–December 1994
Funding:	$ 160,800
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: Approximately two-thirds of all Medicare skilled nursing facility (SNF) stays involve physical, occupational, or speech therapy. The importance of therapy services to the Medicare SNF benefit suggests that changes over time in charges for this service, as well as the patterns of charges between Part A and Part B, need to be tracked. This study employs Medicare provider analysis and review SNF data to examine the characteristics of patients who receive high and very high intensity therapy services, and analyzes episodes of illness of Medicare patients who experience a SNF stay to elucidate the relationship between SNF use and providers of Medicare services. Lewin/VHI's subcontractor, Jill Marsteller of The Urban Institute, is the lead analyst.

Status: A draft report was submitted to the Office of Research and Demonstrations. The final report will be completed by December 1994.

94-074 **Design and Implementation of Medicare Home Health Quality Assurance Demonstration**

Project No.:	500-94-0054
Period:	September 1994–May 1999
Funding:	$ 3,234,881
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Award:	Contract
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard Suite 706 Denver, CO 80222
HCFA Project Officer:	Barbara Greenberg, Ph.D. Division of Long-Term Care Experimentation

Description: Currently, Medicare's home health survey and certification process is primarily focused on structural measures of quality. Although this process provides important information about home health care, an approach based on patient outcome measures would substantially increase the Medicare program's capacity to assess and improve patient well being. To address this need, the Medicare home health quality demonstration will test an approach to developing outcome-oriented quality assurance and promoting continuous quality improvement in home health agencies. The demonstration is designed to serve two purposes: increase Health Care Financing Administration's (HCFA) capacity to assess the quality of Medicare home health care services and increase home health care agencies' ability to systematically evaluate and improve patient outcomes. The proposed quality assurance approach would complement existing home health certification and review programs and could be used with current survey and certification, and peer review organization intervening care screen approaches. The study's conceptual framework for home health quality assessment is based on home health outcomes measures developed under a HCFA-funded study by the University of Colorado, entitled Development of Outcome-Based Quality Measures in Home Health Services (Contract No. 500-88-0054).

Status: This project is in the early developmental stage.

90-032 **Determinants of Home Care Costs**

Project No.:	99-C-98526/1
Period:	August 1990–January 1993
Funding:	$ 125,140
Award:	Cooperative Agreement
Principal Investigator:	Teresa Coughlin
Awardee:	Brandeis University (See page 204)
Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The original purpose of this project was to investigate the determinants of formal and informal home care and the mix of the two types of care. However, two shortcomings in the data for the study period from Connecticut Community Care, Inc. (CCCI), preclude this: prior to January 1991, only the services paid for by CCCI (and not other sources, e.g., Medicaid) were included; and detailed information was not available for informal care. The revised purpose will be to investigate the patterns and determinants of nursing home use in this community-based population, as well as Medicaid spend down among a community-based population.

Status: In the study sample, about 8 percent of the persons were found to enroll in the Medicaid program while still living in the community over a 53-month observation period. As expected, community conversion to Medicaid is driven largely by financial status. What was not expected is that Medicaid conversion did not appear to be influenced by use of medical services. This study did not find any significant relationship between use of drugs or use of hospitals and Medicaid conversion. However, the study did find a marginally significant relationship between temporary nursing home use and conversion. The results also indicate that functional and cognitive status was not significantly related to Medicaid conversion. The final report, "Converting to Medicaid in the Community: The Forgotten Stepchild," will be sent to the National Technical Information Service.

IM-034 **Determinants of Home Health Use**

Funding:	Intramural
HCFA Project Director:	Elizabeth Mauser, Ph.D. Division of Long-Term Care Experimentation

Description: Modifications in the eligibility requirements for Medicare home health services, implementation of the Medicare prospective payment system in hospitals, and beneficiary preferences to remain in the community have resulted in significant increases in Medicare home health care expenditures. Although Medicare home health expenditures continue to rise, relatively little is known about home health users and the market characteristics that affect home health use. Consequently, the Health

Care Financing Administration has implemented several intramural research studies to support future efforts of payment reform in the area of post-acute care. Using the Medicare Current Beneficiary Survey (MCBS), this study is exploring the following issues:

- Whether home health users can be classified into distinct subgroups to understand the special care needs of home health users, determine how specific policies affect different groups of users, and develop case-mix adjustments for payment reform.
- How home health use has changed over time using the 1991, 1992, and 1993 MCBS.
- The effect of supply factors on home health use by linking the MCBS with the area resource file.
- The extent of substitution among different post-acute care settings such as skilled nursing, home health, and rehabilitation facilities.

Status: Using the 1992 MCBS, the characteristics of beneficiaries using Medicare home health were examined and multivariate models were developed to determine the factors that affect utilization and expenditures. Based on this work, the article was prepared. Based on this work, the article, (A Profile of Home Health Users in 1994, by Mauser, E., and Miller, N.A., appeared in the Fall issue of the *Health Care Financing Review*, 16 (1): 17–33, 1994). An analysis has begun of the data from the MCBS matched with the area resource file, and data from the MCBS is being linked with data from the Provider of Service files.

94-023 Development of Outcome-Based Quality Assurance Measures for Small, Integrated Services Settings

Project No.:	HCFA-94-0952
Period:	July 1994–July 1995
Funding:	$ 22,750
Award:	Contract
Principal Investigator:	James Gardner, Ph.D.
Awardee:	The Accreditation Council 8100 Professional Place, Suite 204 Landover, MD 20785
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: The purpose of this contract is to determine the cost of applying outcome measures in small, integrated service settings. This study will provide a data base to maintain information on quality reviews of organizations that serve people with disabilities, an analysis of individual and organizational variables that relate to desirable outcomes, and a final report that analyzes quality reviews conducted in accordance with the outcome-based performance measures developed by the Accreditation Council On Services for People with Disabilities. The results will be used to assess the quality of services in facilities serving people with chronic mental illness, physical challenges, and mental retardation in diverse settings such as supported independent living or intermediate care facilities for the mentally retarded. Of particular importance is the assessment of the extent to which the outcome-based performance measures can coexist with the traditional quality assurance variables such as abuse, neglect, safety, health, and physical and psychological welfare.

Status: A work plan was developed in August 1994. The data collection forms and instructions for data collection were developed, refined, and field-tested in September 1994.

88-023 Development of Outcome-Based Quality Measures for Home Health Services

Project No.:	500-88-0054
Period:	September 1988–July 1994
Funding:	$ 1,965,389
Award:	Contract
Principal Investigator:	Peter Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard Suite 706 Denver, CO 80222
HCFA Project Officer:	Barbara Greenberg, Ph.D. Division of Long-Term Care Experimentation

Description: This study began in late 1988 with funding from both the Health Care Financing Adminstration and the Robert Wood Johnson Foundation. Its purpose is to develop and test outcome-based measures or indicators of quality for Medicare home health services. The measures are designed for use in monitoring and comparing quality of home health care across agencies. The study was designed to have three phases. During the first 15-month development phase, a wide range of approaches to home health care quality assurance and quality measurement were examined. The second phase involved a general feasibility assessment to determine which quality measures to investigate. As a result of this phase, a set of outcome measures was developed. The measures include both end-result outcomes (i.e, measures of patient status and utilization) and intermediate-result outcomes (i.e., measures of nonphysiological or nonfunctional status).

The measures were developed according to different types of patient care needs defined by a patient condition taxonomy termed Quality Indicator Groups (QUIG). The QUIGs can be used to stratify patients into groups for purposes of examining within-condition quality measures or used as case-mix variables/risk factors to be employed in adjusting global outcomes for all patients or larger groups of patients. The third phase was designed to systematically collect data for assessing the reliability, validity, and utility of each outcome measure. In this phase, longitudinal data were collected to measure outcomes for approximately 3,000 patients from 49 home health agencies. Further, preliminary analysis from this phase resulted in an initial design for a Medicare home health quality assurance demonstration.

Status: The final report was submitted in July 1994. The report outlines the findings and conclusions from the final empirical phase of the study and presents the proposed home health outcomes measures system. The article, Measuring and Assuring the Quality of Home Health Care, by Shaughnessy, P.W., Crisler, K.S., Schlenker, R.E., Arnold, A.G., *et al.*, summarizes the findings and appears in the *Health Care Financing Review*, 16 (1): 35-67, Fall 1994.

93-093 **Effect of Geographic Variations on Medicare Capitation Rates for the Social Health Maintenance Organization, Program of All-Inclusive Care for the Elderly, and Community Nursing Organization Projects** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/40
Period:	August 1993–November 1994
Funding:	$ 116,200
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D.
	Division of Long-Term Care Experimentation

Description: The current method of determining capitation payments to be made by Medicare for several demonstration programs (including the Social Health Maintenance Organization, Program of All-Inclusive Care for the Elderly, and Community Nursing Organization) is based on the adjusted average per capita cost methodology, which was developed to establish capitation rates for the Tax Equity and Fiscal Responsibility Act health maintenance organizations. In the above demonstration programs, case-mix models were developed that included individual limitations in activities of daily living and instrumental activities of daily living. These variables are not available for all Medicare recipients; consequently, the local area adjustment needed to measure the cost of enrolling a particular set of persons cannot be made in the usual manner. In this study, synthetic estimates are used to develop appropriate geographic adjustments that can be used in conjunction with national-level data in establishing capitation rate formulas for these and other potential demonstrations. Lewin/VHI's subcontractor, Leonard Gruenberg of DataChron, is the lead analyst.

Status: A draft report was submitted; the final report will be completed in November 1994.

91-097 **Elderly Wealth and Savings: Implications for Long-Term Care** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/17
Period:	June 1991–February 1995
Funding:	$ 126,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D.
	Division of Long-Term Care Experimentation

Description: This study synthesizes what is known about the wealth of the elderly and includes recent empirical research conducted using the 1984 and 1989 Panel Study of Income Dynamics (PSID) and the 1983, 1986, and 1989 Survey of Consumer Finances (SCF). The information in this study is pertinent to the issue of long-term care (LTC) for the elderly because much of the debate concerning expansion of the Federal role in LTC financing centers on the economic status of the elderly. A key issue in the debate is whether or not the elderly have the financial resources to pay for their own LTC cost directly or through the purchase of private LTC insurance. Kevin Coleman of Lewin/VHI, Inc., is the lead analyst.

Status: The main finding of the synthesis report is that the elderly, as a group, are doing well economically. Incomes of the elderly are lower than incomes of the non-elderly, but this gap narrows when taxes and other benefits (i.e., Medicare) are considered. Furthermore, the elderly have among the highest wealth holdings of any

age group. However, the elderly face substantial economic risks such as incurring unfunded catastrophic medical expenses and leaving poverty is harder for the elderly than for the non-elderly. This study also finds that existing theories on both whether and why the elderly save sharply disagree with one another. Testing of these theories is challenging because data sources are usually poor or out of date and many of the theories do not yield refutable hypotheses. A draft report containing the results of the PSID and the SCF data analyses is targeted for completion in December 1994.

92-068 Evaluation of the Community Nursing Organization Demonstration

Project No.:	500-92-0055
Period:	September 1992–February 1997
Funding:	$ 2,414,634
Award:	Contract
Principal Investigator:	Robert J. Schmitz, Ph.D.
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Barbara Greenberg, Ph.D. Division of Long-Term Care Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The Community Nursing Organization (CNO) Demonstration was mandated by section 4079 of the Omnibus Budget Reconciliation Act of 1987. The legislation directs the Secretary of the Department of Health and Human Services to conduct a demonstration project at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the CNO are capitated payment and nurse case management. These two elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. The CNO sites receive a monthly capitation payment for each enrollee. The capitation rate is modeled on the average adjusted per capita cost payment method used for Medicare health maintenance organizations. The CNO per capita payment rate will be set at a level that is equal to 95 percent of the adjusted average per capita Medicare payment for community and ambulatory services in the CNO's geographic area. The legislation mandates the utilization of two types of CNO per capita payment methods. Payment Method A adjusts the per capita payment according to an individual's age, gender, and prior home health use. Payment Method B adjusts the per capita payment according to an individual's functional status in addition to age, gender, and prior home health use. The evaluation of the CNO demonstration will test the feasibility and effect on patient care of a capitated, nurse case-managed service delivery model. Both qualitative and quantitative components are included in the evaluation design. The qualitative component will use a case study approach to examine the operational and financial viability of the CNO model. The quantitative component will use a randomized design to measure the impact of the CNO intervention on mortality, hospitalization, physician visits, nursing home admissions, and Medicare expenditures, as well as on nurse-sensitive outcomes such as knowledge of health problems and management of care.

Status: The four CNO demonstration sites have undergone a 1-year developmental period and began a 3-year operational period in January 1994. Collection of baseline data for CNO enrollees began in January 1994. A site visit report summarizing site activities in the 1-year development period was received in July 1994.

90-065 Evaluation of the Home Health Prospective Payment Demonstration

Project No.:	500-90-0047
Period:	September 1990–June 1995
Funding:	$ 2,858,676 (Phase I)
Award:	Contract
Principal Investigator:	Randall S. Brown, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Elizabeth Mauser, Ph.D. Division of Long-Term Care Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The purpose of this contract is to evaluate Phase I of a demonstration designed to test the effectiveness of using prospective payment methods to reimburse Medicare-certified home health agencies (HHA) for services provided under the Medicare program. In Phase I, a per visit payment method that sets a separate payment rate for each of six types of home health visits (skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and

medical social services) is being tested. Mathematica Policy Research will evaluate the effects of this payment method on HHAs' operations, service quality, and expenditures. The awardee also will analyze the relationship between patient characteristics and the cost and utilization of home health services.

Status: By October 1994, all demonstration agencies will have exited the demonstration. Mathematica has submitted a preliminary impact report based on the findings from the first year of the demonstration. These preliminary findings suggest that treatment agencies have not decreased their cost per visit, have increased their total revenues and net revenues, or have altered their behavior in ways that affect the quality of home health care. The article "Do Preset per Visit Payment Rates Affect Home Health Agency Behavior?" by Phillips, B.R., Brown, R.S., Bishop, C.E., and Klein, A.C. discusses preliminary results from Phase I of the demonstration and appears in the *Health Care Financing Administration*, 16(1):91-107, Fall 1994.

85-001 Evaluation of "Life Continuum of Care" Residential Centers in the United States

Project No.:	18-C-98672/1
Period:	January 1985–September 1989
Funding:	$ 832,871
Award:	Cooperative Agreement
Principal Investigator:	Sylvia Sherwood, Ph.D.
Awardee:	Hebrew Rehabilitation Center for the Aged 1200 Centre Street Boston, MA 02131
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The objective of this project was to obtain information about the characteristics of continuum of care residential centers (CCRC) and their residents and to compare these characteristics, with respect to quality of life and health, service costs, and utilization, with those of elderly residents living in the community. Data were gathered from 19 CCRCs in Arizona, California, Florida, and Pennsylvania. These sites were stratified according to the type of contract offered (extended (9) versus limited (10)), the age of the facility, and the income levels of those enrolled. Three types of CCRC residents were selected from the sites for the study sample: new admissions (580); existing residents, both short- and long-stay residents (1,640); and residents who died just prior to or during the field data gathering period (660). Quality of life and service utilization data were gathered at two points in time, at baseline and 12 months later. Three types of comparison samples were employed: representative sample of elderly in their own homes or independent apartments (2,422); national sample of elderly living in congregate housing settings (2,350); and representative sample of elderly who have died and for whom retrospective data are available for their last year of life (1,500).

Status: Age-stratified comparisons with the Massachusetts community sample showed differences in functional status primarily in favor of the CCRC samples and more of the longer stay of recent CCRC residents or than the Massachusetts elders who spent time interacting with friends. There is a greater predilection for an independent lifestyle on the part of elders who choose CCRCs compared with their age group peers in the community. Despite major differences at baseline between the representative sample of Massachusetts elders as a group and the CCRC sample as a group, many similarities appear in the nature of change from baseline to posttest. Both samples had deterioration in health and functional status from baseline to posttest. However, 8 of the 29 variables examined had differential change. Two were in favor of community residents having more informal helpers and having a confidante. The six in favor of CCRC residents were: ability to do chores/shopping; frequency of going out of the house; frequency of interactions with friends; number of informal helpers who could be relied upon indefinitely; and the extent to which persons have enough money to live on without trouble. These differences generally fit with the concept and opportunities afforded by the CCRC. In terms of health care utilization, the study found that CCRC residents' overall use of Medicare-covered medical services did not differ significantly from that of the traditional community-residing elders. Both groups incurred annual per capita expenditures of approximately $2,000. In their last year of life, however, CCRC residents displayed significantly lower expenditures for hospital care ($3,854 versus $7,268), but higher expenditures for Medicare or non-Medicare-covered nursing home care ($5,565 versus $3,533). The final report will be sent to the National Technical Information Service.

94-081 Evaluation of the Nursing Home Case-Mix and Quality Demonstration

Project No.:	500-94-0061
Period:	September 1994–September 1999
Funding:	$ 2,980,219
Award:	Contract

Principal Investigator: Robert J. Schmitz, Ph.D.
Awardee: Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: Ellen O'Brien
Division of Long-Term Care Experimentation

Description: Through the Nursing Home Case-Mix and Quality Demonstration, the Health Care Financing Administration is investigating the feasibility of paying skilled nursing facilities (SNF) on a prospective basis. Currently, SNFs are retrospectively reimbursed for their reasonable costs. The facility's prospective payment is intended to approximate the actual costs of residents' care. Though some costs will continue to be paid on a retrospective cost basis, the prospective rate will include inpatient routine nursing costs and therapy costs. In addition, quality indicators (QI) will be derived from resident assessment data and will be used to assess the relative performance of participating facilities. The evaluation will analyze facility responses to the demonstration intervention and will assess the usefulness of the QIs in the State survey and certification process. Specific questions to be addressed include:

- Does nursing home prospective payment improve the access of Medicare, particularly heavy-care, patients to SNFs?
- Does prospective case-mix payment affect the pattern of utilization of therapy services?
- Are changes in the costs of SNF care observed at the facility level?
- Are differences in the level and types of services available to residents observed?–i.e., do providers respond to payment incentives to manage more complicated conditions in their facilitiew
- Does the use of QI reports in the survey and certification process improve the informational content of the feedback from surveyors to facilities?

Status: This project is in the early developmental stage.

94-082 Evaluation of Phase II of the Home Health Agency Prospective Payment Demonstration

Project No.: 500-94-0062
Period: September 1994–September 1999
Funding: $ 3,528,408
Award: Contract
Principal Investigator: Barbara Phillips, Ph.D.
Awardee: Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
HCFA Project Officer: Elizabeth Mauser, Ph.D.
Division of Long-Term Care Experimentation

Mandate: Omnibus Budget Reconciliation Act of 1987
(Public Law 100-203)

Description: This contract will evaluate Phase II of the Home Health Agency Prospective Payment Demonstration. This demonstration is testing two alternative methods of paying home health agencies (HHA) on a prospective basis for services furnished under the Medicare program. The prospective payment approaches being tested include payments per visit by type of HHA visit discipline (Phase I) and payment per episode of Medicare-covered home health care (Phase II). Implementation of Phase II, which will test the per episode payment approach, is scheduled to begin in Spring 1995. HHAs that agree to participate are randomly assigned to either the prospective payment method or to a control group that continues to be reimbursed in accordance with the current Medicare retrospective cost system. HHAs will participate for 3 years. The evaluation will combine estimates of program impacts on cost, service use, access, and quality with detailed information on how agencies actually change their behavior to produce a full understanding of what would happen if prospective payment replaced the current cost-based reimbursement system nationally. The findings will indicate not only the overall effects of the change in payment methodology, but also how the effects are likely to vary with the characteristics of agencies and patients. This information will be of great value for estimating the potential savings from a shift to prospective payment for home health care, for indicating where potential problems with quality of care might exist, and for identifying types of patients who might be at risk of restricted access to care as a result of their need for an unusually large amount of care. Because of the relatively small number of agencies participating, the use of qualitative information obtained in discussions with agencies concerning their characteristics and behavior will be essential for avoiding erroneous inferences.

Status: This project is in the developmental phase.

91-017 Evaluation of the Program for All-Inclusive Care for the Elderly Demonstration

Project No.: 500-91-0027
Period: June 1991–February 1996

Funding: $ 4,486,514
Award: Contract
Principal Investigator: Laurence G. Branch, Ph.D.
Awardee: Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: Elizabeth Mauser, Ph.D.
Division of Long-Term Care Experimentation

Mandates: Omnibus Budget Reconciliation Act of 1986
(Public Law 99-509)
Omnibus Budget Reconciliation Act of 1987
(Public Law 100-203)
Omnibus Budget Reconciliation Act of 1990
(Public Law 101-508)

Description: The Program for All-Inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management through which access to and allocation of all health and long-term care services are arranged. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. One purpose of the evaluation is to examine PACE sites before and after assumption of full financial risk with the purpose of determining whether the PACE model of care, as a replication of the On Lok Senior Health Services model of care, is cost effective relative to the existing Medicare and Medicaid programs. Annother purpose is to examine the decision to enroll in PACE in order to understand how PACE enrollees differ from those who are eligible for PACE but refuse to enroll in the program; to determine the impact of PACE on participant health services utilization, expenditures, and outcomes; and to explore the sub-objectives of PACE or the link between PACE and the outcomes of interest.

Status: This project is expected to initiate primary data collection in January 1995. Reports based on site visits to demonstration sites operating under capitated Medicare and Medicaid payments have been received from the awardee.

85-004 Evaluation of Social Health Maintenance Organization Demonstrations

Project No.: 500-85-0042
Period: September 1985–July 1991
Funding: $ 3,533,396
Award: Contract
Principal Investigator: Robert J. Newcomer, Ph.D.
Awardee: Institute for Health and Aging
University of California, San Francisco
201 Filbert Street
Box 0646 Laurel Heights
San Francisco, CA 94133-0646
HCFA Project Officer: Nancy A. Miller, Ph.D.
Division of Long-Term Care Experimentation

Mandates: Deficit Reduction Act of 1984
(Public Law 98-369)
Omnibus Budget Reconciliation Act of 1987
(Public Law 100-203)
Omnibus Budget Reconciliation Act of 1990
(Public Law 101-508)
Omnibus Budget Reconciliation Act of 1993
(Public Law 103-66)

Description: The social health maintenance organization (S/HMO) seeks to enroll, voluntarily, persons 65 years of age or over in an innovative prepaid program that integrates medical, social, and long-term care delivery systems. The S/HMO merges the health maintenance organization concepts of capitation financing and provider risk sharing developed by the Health Care Financing Administration under its Medicare capitation and competition demonstrations with the case management and support services concepts underlying the long-term care demonstrations, serving the chronically ill aged.

Status: An interim report was forwarded to Congress in August 1988. A copy of the report, "Evaluation of the Social Health Maintenance Organization Demonstration," is available from the National Technical Information Service (NTIS), accession number PB89-215446. The evaluation and data collection plan for the demonstration also is available from NTIS as a technical appendix and may be obtained by using accession number PB89-191779. The data collection phase has been

completed. Data analysis has been completed. The following papers and book chapters have been published:

- Harrington, C., Lynch, M., and Newcomer, R.: Medical services in the social health maintenance organizations. *The Gerontologist*, 33(6):790-800, 1993.
- Harrington, C., Newcomer, R., and Moore, T.: Factors that contribute to Medicare HMO risk contract success. *Inquiry*, 25(2):251-262, 1988.
- Harrington, C., and Newcomer, R.J.: Social health maintenance organization service use and costs, 1985–1989. *Health Care Financing Review*, 12(3):37-52, 1991.
- Harrington, C., Newcomer, R., and Preston, S.: A comparison of S/HMO disenrollees and continuing members. *Inquiry*, 30(4):429-440, 1993.
- Harrington, C., and Newcomer, R.J.: Social health maintenance organizations as innovative models to control cost. *Generations*, 14(2):49-54, 1990.
- Manton, K., Newcomer, R., Vertrees, J., Lowrimore, G., and Harrington, C.: A method for adjusting capitation payments to managed care plans using multivariate patterns of health and functioning: The experience of social health maintenance organizations. *Medical Care*, 32(3):277-297, 1994.
- Manton, K.G., Newcomer, R., Vertrees, J., Lowrimore, G., and Harrington, C.: Social health maintenance organization and fee-for-service health outcomes over time. *Health Care Financing Review*, 15(2):173-202, 1993.
- Newcomer, R., and Harrington, C.: Health plan satisfaction among S/HMO members and disenrollees, and Medicare beneficiaries in fee for service care. In *HMOs and Other Health Care Systems for the Elderly* (Luft, H. ed.), Health Administration Press, 1994.
- Newcomer, R.J., Harrington, C., and Friedlob, A.: Awareness and enrollment in the Social HMO. *The Gerontologist*, 30(1):86-93, 1990.
- Newcomer, R.J., Harrington, C., and Friedlob, A.: Social health maintenance organizations: Assessing their initial experience. *Health Services Research*, 25(3):425-454, 1990.
- Newcomer, R., Manton, K., Harrington, C., Yordi, C., and Vertrees, J.: Case Mix Controlled Service Use and Expenditures in the Social Health Maintenance Organization Demonstration. *Journal of Gerontology: Medical Sciences*, 50A(1)M35-M44, January 1995.

Three additional articles are under review. A second Report to Congress is being prepared, based on the published evaluation findings.

89-031 Evaluation and Technical Assistance of the Medicare Alzheimer's Disease Demonstration

Project No.:	500-89-0069
Period:	September 1989–September 1994
Funding:	$ 4,444,674
Award:	Contract
Principal Investigator:	Robert J. Newcomer, Ph.D.
Awardee:	Institute for Health and Aging University of California, San Francisco 201 Filbert Street Box 0646, Laurel Heights San Francisco, CA 94133-0646
HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The purpose of the Medicare Alzheimer's Disease Demonstration is to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services to beneficiaries who have dementia. Two models of care are being studied. Both models include case management and a wide range of in-home and community-based services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models vary by the level and intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that can be paid for by Medicare each month. Some questions to be addressed by the evaluation are:

- What factors are associated with the cost effectiveness of providing an expanded package of home care and community-based services to Medicare beneficiaries with Alzheimer's disease or related disorders?
- How do various services impact on the health status and functioning of dementia patients and their caregivers?
- What are the effects of providing community-based services on caregiver burden and stress?
- Do additional home care services delay or prevent institutionalization of beneficiaries with dementia?

Status: An experimental study design is being used to measure the impact of the Medicare Alzheimer's Disease Demonstration on beneficiaries and their caregivers. Baseline data collection began in December 1989. Since that time, 6,040 beneficiaries have been randomly assigned to the evaluation's treatment and control groups. In addition to the project's intake/assessment instrument, other data sources include:

- A family application form containing demographic information.
- A physician form identifying the type of dementia diagnosis and any other medical conditions.
- Followup interviews with caregivers at 6, 12, 18, 24, and 36 months.
- Claims for Medicare-covered services to obtain information on non-demonstration service utilization and expenditures.
- Bills for Medicare-waivered services to obtain information regarding demonstration service use and expenditures.
- Interviews with the participating organizations' project staff for qualitative and quantitative assessments of program operations and case management protocols.

The final Report to Congress will present project findings and indicate recommendations for possible legislative changes.

93-094 **Examination of the Relation of Part A and Part B Medicare Expenditures** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/9
Period:	December 1992–November 1994
Funding:	$ 175,300
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D.
	Division of Long-Term Care Experimentation

Description: This study is an extension of the analyses of the acute care costs of chronically disabled persons completed using the 1984–89 National Long-Term Care Survey (NLTCS). This analysis utilizes recently released 1989 NLTCS data to examine possible costs shifts for groups of persons with very different levels of health and functioning. Analyses were made of seven different categories of Medicare service (short-stay hospital, home health agency, skilled nursing facility, physician, outpatient, durable medical equipment, and renal and therapy) for the period 1982 to 1990 using Medicare records linked to survey data on community and institutional residents from the NLTCSs of 1982, 1984, and 1989. The purpose of the combined survey and administrative record analyses was to ascertain how the chronic health and functional characteristics of community and institutional residents using Medicare reimbursed services changed over the period and how those changes related to the use of each of seven categories of Medicare services. Over this period a number of regulatory and legislative changes had been made in the Medicare system that altered the use of different services by persons with specific health and functional profiles. Lewin/VHI's subcontractor, Kenneth Manton of Duke University, is the lead analyst.

Status: A draft final report will be completed in October 1994.

93-069 **External Assessment of Quality Assurance in the Program of All-Inclusive Care for the Elderly**

Project No.:	500-92-0014DO02
Period:	September 1993–March 1995
Funding:	$ 389,218
Award:	Delivery Order in Master Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates Inc.
	(See page 206)
HCFA Project Officer:	Elizabeth Mauser, Ph.D.
	Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)
	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)
	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this study is to develop and test an external quality assurance program for the Program of All-Inclusive Care for the Elderly (PACE) model of care. These measures may be used by the Health Care Financing Administration and State Medicaid agencies in quality assurance monitoring of the PACE program. The two key approaches that form the basis for the development of a quality assurance program are a "tracer approach" that identifies certain events whose existence represents a sign of unsatisfactory care, and "general patient-centered measures" of health outcomes

that reflect the total effects of care on the individual patient. The quality assurance approach encompasses both process and outcome elements.

Status: Tracer conditions have been developed by the University of Minnesota, the subcontractor for this delivery order. The University of Minnesota has obtained copies of medical records from each of the PACE sites and has recruited and trained reviewers to abstract the necessary information from the medical records.

93-095 **Health Care Service Use and Expenditures of the Noninstitutionalized Population** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/8
Period:	June 1993–February 1995
Funding:	$ 148,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D Division of Long-Term Care Experimentation

Description: Utilizing data from the 1987 National Medical Expenditures Survey Household Component, this study addresses:

- Differences in the utilization of health care services by disabled and non-disabled populations.
- Whether or not community-based long-term care services and expenditures substitute for acute care expenditures for the population using community-based long-term care services and the implications on costs.
- Medicaid asset spend down in the community.
- Trends in out-of-pocket expenditures and total health care expenditures for the elderly population with comparisons to the 1977 National Medical Care Expenditure Survey.

Lisa Alecxih of Lewin/VHI, Inc., has been leading this investigation.

Status: Analysis files have been constructed. A draft report should be completed by January 1995.

90-011 **Home Care Quality Studies**

Project No.:	500-89-0056
Period:	October 1989–September 1995
Funding:	$ 2,848,782
Award:	Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	The University of Minnesota School of Public Health D-351 Mayo Memorial Building 420 Delaware Street, SE., Box 197 Minneapolis, MN 55455-0392
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation

Description: For this study, the awardee will carry out research on the quality of long-term care services in community-based and custodial settings and the effectiveness of (and need for) State and Federal protections for Medicare beneficiaries that ensure adequate access to nonresidential long-term care services and protection of consumer rights. The awardee will focus on in-home care, examining traditional home health services that are reimbursed by Medicare and Medicaid, as well as personal care and supportive services that more recently have been covered by Federal and State sources of funding. Primary project tasks include:

- Development of a taxonomy clarifying the various objectives ascribed to home and community-based care from the various perspectives of consumers, payers, and care providers.
- Development and feasibility testing of a survey design measuring the extent of, need for, and adequacy of home care services for the elderly.
- A study of variations in labor supply and related effect(s) on home care quality, as well as factors that contribute to these variations.
- Recommendations to improve the quality of home and community-based services by identifying best practices and promising quality assurance approaches.

Status: The first project task (development of a taxonomy of objectives) has been completed, and a report on this component has been received. Findings from this task are presented in the article, "Perspectives on Quality of Home Care" by Kane, R.A., Kane, R.L., Illston, L.H., and Eustis, N.N. in the *Health Care Financing Review*, 16(1):69-89, Fall 1994. The University of Minnesota is continuing work on each of the remaining primary tasks. The final report is expected in September 1995.

90-021 **Implementation of the Home Health Agency Prospective Payment Demonstration**

Project No.:	500-90-0024
Period:	June 1990–June 1995
Funding:	$ 1,629,606
Award:	Contract

Principal Investigator: Henry Goldberg
Awardee: Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: Phyllis A. Nagy
Division of Long-Term Care Experimentation

Mandate: Omnibus Budget Reconciliation Act of 1987
(Public Law 100-203)

Description: This contract implements and monitors the demonstration design for the Home Health Agency Prospective Payment Demonstration, which was developed under an earlier contract with Abt Associates Inc. The project will implement a demonstration testing two alternative methods of paying home health agencies (HHA) on a prospective basis for services furnished under the Medicare program. The prospective payment approaches to be tested include payments per visit by type of discipline (Phase I), and payments per episode of Medicare-covered home health care (Phase II). HHA participation is voluntary.

Status: Following an initial recruitment of HHAs, operations under Phase I were implemented on October 1, 1990. Forty-nine HHAs were recruited. All agencies under Phase I will have completed their 3-year participation as of October 1994. Implementation of Phase II, which will test the per episode payment approach, is scheduled to begin in spring 1995. Recruitment for Phase II agencies will begin in fall 1994. In each phase, HHAs that agree to participate are randomly assigned to either the prospective payment method or to a control group that continues to be reimbursed in accordance with the current Medicare retrospective cost system. HHAs will participate in the demonstration for 3 years.

94-062 Implementation of the Multistate Nursing Home Case-Mix and Quality Demonstration

Project No.: 500-94-0010
Period: February 1994–July 1996
Funding: $ 3,209,538
Award: Contract
Principal Investigator: Robert E. Burke, Ph.D.
Awardee: Allied Technology Group, Inc.
1803 Research Boulevard, Suite 601
Rockville, MD 20850

HCFA Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: This contract will support the implementation phase of The Multistate Nursing Home Case-Mix and Quality Demonstration. The demonstration combines the Medicare and Medicaid nursing home payment and quality monitoring system across several States: Kansas, Maine, Mississippi, New York, South Dakota, and Texas. This project builds on past and current initiatives with case-mix payment and quality assurance in nursing homes. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of process and outcomes adjusted for case mix. The project will have three phases: systems design and development, systems implementation and monitoring, and evaluation.

The objectives of the implementation phase are to:

- Recruit facilities in the six demonstration States to participate in the Medicare portion.
- Develop and operate the Medicare case-mix system of the demonstration for the Health Care Financing Administration, which involves the fiscal intermediaries and the Medicare skilled nursing facility providers.
- Develop a valid therapy payment component for inclusion in the Medicare case-mix payment rate.
- Conduct a staff-time measurement study to validate the Resource Utilization Group, Version III classification system.
- Validate the quality indicators and implement the quality monitoring system in the demonstration States through the States' nursing home survey process.
- Implement an Administrative Management and Operational System that links distinct components of the demonstration (e.g., classification of residents, Medicare eligibility determination, payment systems, outcome monitoring for quality, and assessment reliability).
- Implement a field auditing system that monitors States and nursing home facilities participating in the Medicare portion.

Status: Implementation of the Medicaid prospective payment system was phased in July 1993. Implementation of the Medicare prospective payment system and quality monitoring systems is projected for January 1995.

94-024 **Improving the Discharge Planning Process**

Project No.:	500-92-0048DO02
Period:	March 1994–March 1995
Funding:	$ 130,471
Award:	Delivery Order in Master Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	The University of Minnesota (See page 210)
HCFA Project Officer:	Barbara Greenberg, Ph.D. Division of Long-Term Care Experimentation

Description: Enactment of the Medicare prospective payment system has focused attention on discharge planning. The increased pressure to eliminate medically unnecessary hospital days and the shorter amount of time available for discharge planning has underscored the need to develop a discharge planning process that better relates post-acute care services to patient outcomes. The purpose of this project is to examine approaches for improving discharge planning and for recommending innovative research or demonstration projects.

Status: A concept paper is being developed. A technical expert panel will meet in fall 1994.

91-055 **Interaction of Medicaid and Private Long-Term Care Insurance**

Project No.:	99-C-98526/1
Period:	August 1991–July 1993
Funding:	$ 80,000
Award:	Cooperative Agreement
Principal Investigator:	Christine Bishop, Ph.D.
Awardee:	Brandeis University (See page 204)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: For this study, researchers will examine the characteristics of purchasers and nonpurchasers of private long-term care (LTC) insurance, the types of insurance purchased, and the role of State Medicaid program characteristics and personal characteristics in influencing the purchase decision.

Status: The study found that, after accounting for available control variables, purchase of private LTC insurance is less likely where Medicaid supports a relatively high level of input intensity in nursing homes; where nursing home beds are more available; and where higher income persons may be eligible for Medicaid as "medically needy" because of nursing home spending. These results suggest that the Medicaid "safety net" deters LTC insurance purchase, and that improvements in Medicaid coverage of LTC may further suppress demand for private LTC insurance. The final report will be sent to the National Technical Information Service.

94-045 **Interrelationship of Medical Conditions in the Nursing Home Population**

Project No.:	500-89-0047/43
Period:	January 1994–December 1995
Funding:	$ 67,600
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: This project, conducted in collaboration with the Health Care Financing Administration (HCFA), uses concatenated Medicare provider analysis and review, skilled nursing facility (SNF), and minimum data set plus data to develop a richer profile of Medicare SNF patients. Data for each patient include his/her clinical conditions, his/her subsequent use of Medicare hospital and SNF services, and his/her use of non-Medicare-covered nursing home services. This is a "pilot" study that focuses on three States (Maine, Mississippi, and South Dakota) and on patients with selected conditions (congestive heart failure, hip fracture/replacement, chronic obstructive pulmonary disease, pneumonia, and cardiovascular attack). This study also examines the characteristics of nursing home patients who are under 65 years of age. This work has been subcontracted to Jill Marsteller of The Urban Institute and is being done in collaboration with HCFA's analyst, Elizabeth Cornelius.

Status: This project will be completed in December 1994.

92-099 **Issues in Long-Term Care Policy for the Disabled Elderly with Cognitive Impairment**
(Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/21
Period:	January 1992–March 1995
Funding:	$ 180,000
Award:	Contract

Principal Investigator: David Kennell
Awardee: Lewin/VHI, Inc.
(See page 153)
HCFA Project Officer: Judith A. Sangl, Sc.D.
Division of Long-Term Care Experimentation

Description: This study utilizes the National Long-Term Care (NLTC) surveys to analyze issues related to informal caregiving to cognitively impaired elderly people, the mix of formal and informal services they use, and the risk of institutionalization. The main question addressed is whether the presence of such factors as behavioral problems or conditions (e.g., incontinence) that imply special service needs affect the mix of services used or the risk of institutionalization. This work will be completed by Judith Kasper of The Johns Hopkins University School of Hygiene and Public Health under subcontract to Lewin/VHI.

Status: The article, "Cognitive Impairment and Problem Behaviors as Risk Factors for Institutionalization," by Judith Kasper and Andrew D. Shore, describes the first part of this study and appears in *The Journal of Applied Gerontology*, 13(4):371–385, December 1994. The NLTC survey data were used to develop a predictive model for nursing home institutionalization that includes cognitive functioning and problem behaviors in addition to more commonly studied indicators such as disability. As expected, cognitive impairment is a risk factor for institutionalization, controlling for other characteristics such as age, living arrangement, and use of paid in-home care. Four problem behaviors were investigated, but only one, Wanders/Gets Lost, contributed to the model. Among cognitively impaired persons, those who wander/get lost had a two-fold risk of institutionalization. The findings suggest the need to differentiate among difficult or problem behaviors and to further investigate those that arouse concerns about safety and require extensive supervision as risk factors for institutionalization. The second part of this study that examines survey data combined with Medicare claims will be completed by March 1995.

93-096 Key Issues for Private Long-Term Care Insurance (Formerly, Long-Term Care Studies (Section 207))

Project No.: 500-89-0047/18
Period: December 1992–December 1994
Funding: $ 167,900
Award: Contract
Principal Investigator: David Kennell
Awardee: Lewin/VHI, Inc.
(See page 153)
HCFA Project Officer: Judith A. Sangl, Sc.D.
Division of Long-Term Care Experimentation

Description: Although the number of private long-term care (LTC) insurance policies in force has grown substantially over the last few years, there continue to be concerns about the ultimate market penetration and the form policies will take. In addition, a variety of legislative proposals and strategies that would impact the role of private LTC insurance exist. This study addresses key issues for private long-term care insurance. The three components of this study are an assessment of key standards currently being debated (e.g., rate stabilization), an assessment of current policies, and a paper detailing the possible post-reform roles of private LTC insurance. This project will be carried out jointly by Lewin/VHI (Lisa Alecxih) and The Brookings Institution.

Status: A draft report will be completed by October 1994.

94-013 Life Insurance Predeath Benefit Industry Study

Project No.: HCFA-94-0423
Period: March 1994–June 1994
Funding: $ 24,758
Award: Contract
Principal Investigator: Leonard Gruenberg, Ph.D.
Awardee: DataChron Health Systems
763 Massachusetts Avenue, Suite 7
Boston, MA 02139
HCFA Project Officer: Kay Lewandowski
Division of Long-Term Care Experimentation

Description: This project was designed to study the prevalence, types, and implications of life insurance predeath benefits as a mechanism to assist the terminally ill in shifting their life insurance policies from postdeath to predeath benefits. The use of the predeath benefit (also known as an accelerated death benefit, terminal period benefit, or living benefit) as a way of meeting the needs of the terminally ill is becoming a recognized option for financing long-term care services.

Status: The final report for this initial study has been completed. Using data collected as part of the project, the

report provides information on the history of the benefit; the insurance carriers or other organizations either offering the benefit or facilitating the transfer of this asset; the types of plans available, by organization, including a description of applicable policies, requirements for participation, and period of time over which the benefit can be accessed; the participant characteristics; the implementation and administration problems of carriers and recipients; and the State and Federal Government issues such as participant eligibility and tax implications.

94-044 Longitudinal Health Care Use and Expenditures of Disabled Persons

Project No.:	500-89-0047/42
Period:	January 1994–June 1995
Funding:	$ 143,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: This project, conducted in collaboration with the Health Care Financing Administration (HCFA), uses data from the Medicare Current Beneficiary Survey to examine health care use by persons with disabilities and the cost of providing these services. In this study Medicare beneficiaries are categorized by different definitions of disability and by duration of disability. An analysis of the types of health care services and patterns of use for each subgroup is performed to determine the extent to which differences in such constructs are associated with differences in health care use and costs. This study is designed, in part, to provide parallel information with that from Lewin/VHI's analysis of National Medical Care Expenditure Survey data and Duke University's analysis of National Long-Term Care Survey data. This work has been subcontracted to Korbin Liu of The Urban Institute and is being done in collaboration with HCFA analysts, Judith Sangl and Carolyn Rimes.

Status: This project will be completed in June 1995.

89-030 Long-Term Care Case-Mix and Quality Technical Design Project

Project No.:	500-89-0046
Period:	September 1989–December 1993
Funding:	$ 3,097,982
Award:	Contract
Principal Investigator:	Robert E. Burke, Ph.D.
Awardee:	The Circle, Inc. 8201 Greensboro Drive, Suite 600 McLean, VA 22102
HCFA Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: This 4-year contract has supported the design phase of The Multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration. The demonstration combines the Medicare and Medicaid nursing home payment and quality monitoring system across several States: Kansas, Maine, Mississippi, New York, South Dakota, and Texas. This project builds on past and current initiatives with case-mix payment and quality assurance in nursing homes. The purpose is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of process and outcomes adjusted for case mix. The project will have three phases: systems design and development, systems implementation and monitoring, and evaluation.

Status: The classification system to be used for Medicare and Medicaid across the demonstration States was completed in June 1991 by researchers from The University of Michigan and Rensselaer Polytechnic Institute. The resource utilization group, version III (RUG-III), uses 44 groups to explain approximately 45 percent of the variance in nursing staff time and 52 percent of the costs across nursing, occupational therapy, physical therapy, speech pathology, transportation, and social work services. The RUG-III groups are split on clinical conditions, including signs and symptoms of distress, type and intensity of service, and activities of daily living. The 27 groups at the top of the classification system closely correlate with the Medicare coverage criteria. Four papers covering the analyses done on developing the classification system have been published or are being reviewed for publication. A working paper, "Description of the Resource Utilization Group, Version III (RUG-III)," which describes the classification, is available from the Division of Long-Term Care Experimentation. The common assessment tool, the minimum data set plus (MDS+), has been developed and implemented as the State resident assessment instrument in the demonstration States. A training manual which includes the MDS+ and the resident assessment protocols has been published:

Feldman, J., and Boulter, C., eds.: *Minimum Data Set Plus (MDS+). Multistate Nursing Home Case-Mix and Quality Demonstration Training Manual.* Natick, MA. Eliot Press, 1991. A coordinated effort has been undertaken to develop the State-specific Medicaid payment systems. Four Medicaid systems have been completed and are being implemented at the present time. The analysis of 1990 Medicare Cost Reports and 1990 case-mix data to develop the Medicare payment design are completed. A working paper, "Issue Paper on Development of Medicare SNF Payment Rates," has been developed and distributed to persons working on the payment system design. The Medicare payment system portion of the demonstration is expected to be approved for implementation in early 1995. Under a subcontract with Allied Technology, the University of Wisconsin's researchers have completed the development of a preliminary list of 30 facility-level quality indicators (QI) that were used in a 4-State pilot test. They were reviewed by expert surveyors from the 6 States, a research-oriented quality panel, and a clinical work group of 60 health professionals representing about 15 disciplines working in long-term care. A working paper, "Description of the Quality Indicators and System for Using Them in the Nursing Home Survey Process," has been developed and distributed to persons interested in the demonstration. The QIs will serve to enhance the quality assurance process to be used for the operational phase. The final set of QIs will be implemented demonstration wide in 1995. The final report of the technical design phase of The Multistate NHCMQ Demonstration was received in January 1994. The products of the design phase include several software programs.

- A modified 1.01 version of Malitz, D., Ph.D., and Godbout, R.C., Ph.D.: PC Group: A Statistical Package Software for Interactive Data Exploration and Model Building for cluster analysis-tested, revised in 1990 and an updated 3.01 to Group PC Version, revised in 1992—available from Austin Data Management Associates, Post Office Box 4358, Austin, Texas 78765, (512) 320-0935.
- The Grouper, Classification Algorithm for RUG III using the MDS+, 1992.
- M^3PI Processor, Classification software for RUG III and M^3PI using the MDS+.
- MDS+ Analytic Data Base and Management Software, 1993.
- An RSM/STM Research Data Base, 1991, developed from the Resident Status Measure and Staff Time Measurement (RSM/STM) Study in seven States.
- Clinical Profiles of RMS/STM Study Population in EXCEL.
- RUG III Grouping Algorithm Using MEDPAR, 1993.

89-011 Long-Term Care: Elderly Service Use and Trends

Project No.:	17-C-99376/3
Period:	August 1989–June 1991
Funding:	$ 245,249
Award:	Cooperative Agreement
Principal Investigator:	Joshua Wiener, Ph.D.
Awardee:	The Brookings Institution 175 Massachusetts Avenue, NW. Washington, DC 20036-2188
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: This project has three objectives: an analysis of the financial status of nursing home users; an analysis of the determinants of home care use; and projections of the numbers and level of disability among the elderly and their use of long-term care (LTC) services. Data from the 1982 and 1984 National Long-Term Care Surveys (NLTCS), the 1984–86 Supplement on Aging/Longitudinal Study of Aging; and the 1984 Survey of Income and Program Participation. Data will be analyzed using cross-tabulations, logistic and least squares regression analyses, and the Brookings/Intermediate Care Facility (ICF) simulation model (updated and revised).

Status: The study findings of the five major components are:

- "Will Paid Home Care Erode Informal Support?"

One of the main barriers to the expansion of paid home care for the chronically disabled is the fear that policymakers have that it will cause friends and relatives to curtail their informal care caregiving efforts. Using the first wave of the NLTCS, researchers examined whether the amount of paid home care used by disabled elderly persons had a significant influence on the amount of informal support they received. Results from a two-stage least squares regression analysis suggest that the amount of informal home care received was not significantly affected by the level of formal care. This conclusion held for subgroups of formal care users most likely to exhibit substitution: those without cognitive problems, the disabled elderly with above average income, and persons who lived alone. Even the more severely disabled elderly, who are the target of most proposals to expand

paid home care, did not substitute paid care for unpaid. Thus, the study suggests that an increase in paid home care will not erode informal support. This finding has been published in the *Journal of Health Politics, Policy and Law* 16(3):507-521, Fall 1991.

- "Use of Paid Home Care by the Chronically Disabled Elderly"

Determinants of paid home care use among the chronically disabled elderly were analyzed using the 1982 NLTCS. In 1982, about one quarter of the elderly disabled had a paid home care provider. Using logistic regression, our analysis found the predictors of any use of paid home care were age, sex, marital status, number of daughters and sons, problems with activities of daily living, a prior nursing home stay, an overnight hospital stay in the last year, income, home equity, and Medicaid enrollment. Using ordinary least squares regression, the study identified predictors of the amount of formal care used in the last week. For the elderly with a paid home care provider, greater age, greater disability, not being married, fewer daughters, and cognitive impairment signal significantly more use. This finding has been published in *Research on Aging* 13(3):310–332, September 1991.

- "The Economic Status of Elderly Nursing Home Users"

Using the 1982–1984 NLTCS, the 1984 Survey of Income and Program Participation, and the Brookings-ICF Long-Term Care Financing Model, this paper examines the financial status of the elderly in nursing homes. These analyses suggest that nursing home residents are relatively low-income people with modest levels of assets. Only a very small percentage could be considered well-to-do or are poor enough to qualify for Medicaid upon admission, while the vast majority are at appreciable risk of exhausting their savings to cover an extended stay. Over the next three decades, the Brookings-ICF Long-Term Care Financing Model estimates that virtually no nursing home users could afford a single-year stay financed exclusively from income. More than two-in-three could spend all of their income and savings and still find a l-year stay unaffordable. Only by using accumulated home equity could a majority of elderly nursing home users afford to finance their care over this length of time. Finally, financial status declines precipitously between retirement and first nursing home use. At the time of their first entry to a nursing home, 31 percent of nursing home admissions had less than half of the income and assets they had at age 67. About half had less than 70 percent of their initial retirement income and assets at the time of admission to a nursing home.

- "Predicting Elderly Nursing Home Admissions: The Longitudinal Study of Aging"

A rapidly growing elderly population will lead to substantially greater spending for LTC far into the next century, placing a strain on both public and private resources. Improving our ability to predict those persons most likely to use nursing home care will be a key factor in better organizing and financing nursing home and home care. This study uses the Longitudinal Study of Aging (LSOA) to extend our earlier work on the risk of institutionalization. Prior nursing home stay, functional status, and age are significant at the .01 level. Low income is either significant or almost significant at the .05 level, depending on the equation. Living alone almost approaches significance at the .05 level, reflecting the importance of living arrangement. Receipt of formal care and home ownership are not significant predictors of nursing home use. Severe data limitations with the LSOA require that these findings be interpreted cautiously.

- "Effects of Changing Disability Rates on Long Term Care Use and Expenditures"

Changing disability patterns and increasing numbers of elderly persons are likely to have a profound effect on the use of LTC services in the next century. Alternative views of how declining mortality rates, particularly among the very old, will interact with disability/morbidity rates in this population are discussed, and LTC use and expenditures, are projected for 2,018 using the Brookings-ICF Long-Term Care Financing Model. Projections using relatively low disability rates model the "compression of morbidity" theory whereby the older population is healthier in the future as illness is postponed until the last years of life because of medical advances in the treatment and prevention of chronic disease. Projections using relatively high disability rates reflect the "expansion of morbidity" theory which posits a more sick older population because of increases in chronic disease and associated disability. The central finding is that differing disability rates have a major impact on future LTC use and expenditures but even under low disability scenarios, nursing home and home care use and spending will increase substantially over the next 25 years. The final report will be sent to the National Technical Information Service.

92-027 **Long-Term Care Program and Market Characteristics**

Project No.:	18-C-90034/9
Period:	February 1992–September 1995
Funding:	$ 808,047
Award:	Cooperative Agreement
Principal Investigator:	Charlene Harrington, Ph.D.
Awardee:	University of California, San Francisco Office of Research Affairs 3333 California Street, Suite 11 San Francisco, CA 94143-0962
HCFA Project Officer:	Kay Lewandowski Division of Long-Term Care Experimentation

Description: This project will collect data on and study the effects of nursing home and home health care characteristics and markets on Medicare and Medicaid services in the 50 States. Primary and secondary data for the 1990–94 period will be collected to update earlier data on previous studies for the 1978–89 period. Through surveys, data will be collected on licensed nursing home bed supply and occupancy rates, State certificate of need programs, State preadmission screening programs, and Medicaid nursing home and home health reimbursement. Data also are being collected on Medicaid waiver programs, Boren amendment litigation, provider characteristics, resident characteristics and deficiencies of nursing homes. Analysis will provide detailed information on each State's current methodology for determining nursing home capital costs, the impact of proposed case-mix reimbursement on operating income, reimbursement methodology for freestanding subacute units, and Medicaid methodology used to reimburse for care provided in board and care homes, geriatric day care centers, and intermediate care facilities for the mentally retarded. A publicly accessible data base will be developed that will provide a complete set of demonstration data for the period 1978–94.

Status: The first 2 years of the project have been completed, with a continuation of the studies for the third year under way. An additional study is planned for the third year to collect information on State loan programs to identify those agencies making loans to health care facilities. The State data book presenting data on long-term care program and market characteristics across the 50 States and the District of Columbia has been published: *State Data Book on Long-Term Care Program and Market Characteristics*, Health Care Financing Extramural Report, HCFA Pub. No. 03354, Health Care Financing Administration. U.S. Government Printing Office Washington. August 1994.

89-034 **Long-Term Care Studies (Section 207)**

Project No.:	500-89-0047
Period:	September 1989–July 1995
Funding:	$ 3,790,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. 9302 Lee Highway, Suite 500 Fairfax, VA 22031-1207
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The purpose of this project is to conduct research related to the Health Care Financing Administration's Medicare and Medicaid programs in the area of long-term care (LTC) policy development. The awardee primarily will focus on four major areas:

- The financial characteristics of Medicare beneficiaries who receive or need LTC services.
- How the Medicare beneficiaries' characteristics affect their utilization of institutional and noninstitutional LTC services.
- How relatives of Medicare beneficiaries are affected financially and in other ways when beneficiaries require or receive LTC services.
- How the provision of LTC services may reduce expenditures for acute care health services.

Analyses will use existing LTC and other survey data bases (e.g., the National Long-Term Care Surveys, the Longitudinal Study of Aging, the National Nursing Home Survey, the Medicare Current Beneficiary Survey, the Survey of Income and Program Participation, and the National Medical Care Expenditure Survey). Medicare administrative records and other extant information also will be utilized. A number of focused analytic studies, policy reports, syntheses, and special studies are required under the contract.

Status: With the repeal of the Medicare Catastrophic Coverage Act of 1988, this project is no longer congressionally mandated. A large number of studies

have been initiated, and several draft and final reports have been received. Current studies include:

- Analysis of Choice Processes in Capitated Plan Enrollment: Statistical Models for Evaluation of Voluntary Enrollment to Long-Term Care Demonstration Projects.
- Analysis of Informal and Formal Care.
- Analysis of Nonparticipation in the 2176 Program.
- Analysis of Nursing Home Payment with Current Beneficiary Survey Data.
- Analysis of Post-Acute Care and Therapy Services Using the Health Care Financing Administration Episode Data Base.
- Analysis of Transitions in the Characteristics of the Long-Term Care Population.
- Case Studies of Medicaid Estate Planning.
- Catastrophic Costs and Medicaid Spenddown.
- Catastrophic Costs of Long-Term Care.
- Consumer Protection and Private Long-Term Care Insurance.
- Costs of Medicare Skilled Nursing Facility Therapy.
- Effect of Geographic Variations on Medicare Capitation Rates for the Social Health Maintenance Organization, Program of All-Inclusive Care for the Elderly, and Community Nursing Organization Projects.
- Elderly Wealth and Savings: Implications for Long-Term Care.
- Examination of the Relation of Part A and Part B Medicare Expenditures.
- Health Care Service Use and Expenditures of the Noninstitutionalized Population.
- Interrelationship of Medical Conditions in the Nursing Home Population.
- Issues in Long-Term Care Policy for the Disabled Elderly with Cognitive Impairment.
- Key Issues for Private Long-Term Care Insurance.
- Longitudinal Health Care Use and Expenditures of Disabled Persons.
- Potential of Coordinated Care Targeted to Medicare Beneficiaries with Medicaid Coverage.
- Regional Variation in Home Health Episode Length and Number of Visits Per Episode.
- Simulations of Skilled Nursing Facility Payment Options.
- State Responses to Medicaid Estate Planning.
- Synthesis of Financing and Delivery of Long-Term Care for the Disabled Non-Elderly.
- Synthesis of Literature on Effectiveness of Special Assistive Devices in Managing Functional Impairment.
- Synthesis of Literature on Targeting to Reduce Hospital Use.
- Synthesis of Reimbursement Options.
- Synthesis of the Nursing Home Bed Supply.
- Synthesis of Unmet Need for Long-Term Care Services.

A conference to present selected findings is scheduled for November 1994 and conference proceedings will be published by July 1995.

90-056 Long-Term Care Survey

Project No.:	HCFA-IA-9155
Period:	September 1990–February 1993
Award:	Interagency Agreement
Principal Investigator:	Richard Sussman
Awardee:	National Institute on Aging 9000 Rockville Pike Bethesda, MD 20892
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The Office of the Assistant Secretary for Planning and Evaluation and the Health Care Financing Administration (HCFA) agree to transfer funds to the National Institute on Aging (NIA) to support an existing NIA grant to Duke University, Center for Demographic Studies. This grant, number 1R37AG07198, is entitled Functional and Health Changes of the Elderly, 1982–89. The National Long-Term Care Survey (NLTCS) is a detailed household survey of persons 65 years of age or over who have some chronic (90 days or more) functional impairment. The survey has been administered three times. The first, conducted in 1982, was devised as a cross-sectional survey. The second, conducted in 1984, added a longitudinal component to the sample design. The third, administered in 1989, used the cohorts from the previous surveys in addition to persons becoming 65 years of age to form a nationally representative sample of impaired elderly persons. To facilitate the use of the data base, these tasks related to the 1982, 1984, and 1989 NLTCSs will be carried out under this agreement:

- File linkage over the entire period 1982–89.
- Derivation of new longitudinal sample weights.
- Linkage of Medicare administrative records.
- Improvement of coding by checking consistency of survey items.
- Improvement in survey documentation.
- Seminars and education.

Status: A second version of the public use data file containing Medicare Part A and B files was sent to the Michigan Archives in fall 1993. This public use version can be obtained from Michigan Archives by calling

(313) 763-5011. However, this second version recently has been found to have incomplete Medicare data for certain years; another version with complete Medicare data will be sent to the Michigan Archives once Medicare files have been received from HCFA.

94-089 MAINE-NET: Medicaid- and Medicare-Managed Care for the Elderly and Physically Disabled in Maine

Project No.:	11-C-90437/1
Period:	September 1994–September 1997
Funding:	$ 944,940
Award:	Cooperative Agreement
Principal Investigator:	Carreen Wright
Awardee:	Maine Department of Human Services Bureau of Medical Services State House Station No. 11 Augusta, ME 04333
HCFA Project Officer:	Kay Lewandowski Division of Long-Term Care Experimentation

Description: This project is designed to demonstrate integrated models for the financing and delivery of managed health care and social services for Medicare and Medicaid elderly and physically disabled persons in Maine. The project seeks to promote the development of regional service delivery networks or health plans, particularly in rural areas of the State that would be responsible for the management, coordination, and integration of services (including multidisciplinary approaches to care planning and service delivery). The demonstration will provide a comprehensive package of primary, acute, and long-term care (institutional and noninstitutional) services as part of a prepaid-capitated health plan for the target populations. The demonstration will use and expand nursing home quality indicators developed in the Health Care Financing Administration (HCFA)-sponsored Multistate Case-Mix Demonstration Project and will incorporate HCFA's quality assurance guidelines for managed care plans. In addition, the project will develop and use an activity of daily living-based case-mix adjustment for long-term care services in the construction of capitation payment rates, using the resource utilization group III classification system also developed in the multistate demonstration project. For services provided in boarding homes and in the community, two new case-mix methodologies will be developed for use by the demonstration.

Status: This project is in the early developmental stage.

94-079 Managed Care System for Disabled Children and Youth with Special Needs

Project No.:	18-P-90488/3
Period:	August 1994–August 1995
Funding:	$ 150,000
Award:	Grant
Principal Investigator:	David Coronado
Awardee:	Government of the District of Columbia Commission on Health Care Finance 2100 Martin Luther King Jr. Avenue, SE., Suite 302 Washington, DC 20020
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation

Description: The District of Columbia submitted a request for section 1115 waivers, which will permit it to implement a Medicaid-managed care initiative to serve approximately 3,600 children with disabilities and complex medical needs.

Status: A number of key issues within the waiver application required clarification. For example, it was felt the District of Columbia needed to clearly identify cost projections, a sufficiently detailed reimbursement methodology, and an appropriate service delivery system. As a result, the District of Columbia was awarded grant funding to support a 12-month developmental phase beginning in August 1994. This developmental phase will provide sufficient opportunity for the District of Columbia to obtain technical assistance and to resolve outstanding issues.

93-006 Managing Medical Care for Nursing Home Residents: United HealthCare Corporation, Inc. (Formerly, Managing Medical Care for Nursing Home Residents)

Project No.:	95-C-90174
Period:	December 1992–December 1998
Funding:	Waiver only
Award:	Cooperative Agreement
Principal Investigator:	Jeannine Bayard
Awardee:	United HealthCare Corporation, Inc. P.O. Box 1459 Minneapolis, MN 55440-8001
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation

Description: The objective of this demonstration is to study the effectiveness of managing acute care needs of nursing home residents by pairing physicians and geriatric nurse practitioners (GNP) who will function as primary medical caregivers and case managers. The major goals are to reduce medical complications and dislocation trauma resulting from hospitalization and to save the expense of hospital care when patients could be managed safely in nursing homes with expanded services. The operating principal is EverCare, a subsidiary of United HealthCare Corporation, Inc. EverCare will receive a fixed capitated payment (based on a percentage of the adjusted average per capita cost) for all nursing home residents enrolled and will be at full financial risk for the cost of acute care services for the enrollees. Nine demonstration sites are expected to participate, with each site enrolling approximately 300 persons. GNPs will provide initial assessments of enrollees; make monthly visits; authorize clinic, outpatient, and hospital visits; and communicate with the patients' physicians, nursing facility staffs, and families. Physician incentive plans will be structured to offer a higher reimbursement rate for a nursing home visit and a lower reimbursement rate for services furnished in physicians' offices or in other settings. By increasing the intensity and availability of medical services, EverCare believes that this case management model will reduce total care costs; improve the quality of care received by participants through better coordination of appropriate acute care services; and improve the quality of life for and the level of satisfaction of enrollees and their families.

Status: Waivers were awarded in late summer 1994 and EverCare is in the process of securing the appropriate State approvals for operating in the nine targeted States. Work has centered on identifying payment methodologies for primary care physicians, identifying barriers to marketing approaches through the use of customer focus groups, and interviewing staff for several of the target sites. Site operations are expected to begin during the first quarter 1995.

94-087 Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration with Other Care Settings on Patient Outcomes

Project No.:	17-C-90435/8
Period:	September 1994–December 1997
Funding:	$ 1,231,466
Award:	Cooperative Agreement
Principal Investigator:	Peter W. Shaugnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard Suite 706 Denver, CO 80222
HCFA Project Officer:	Elizabeth Mauser, Ph.D. Division of Long-Term Care Experimentation

Description: Home health care (HHC) is the most rapidly growing component of the Medicare budget in recent years. The rapid growth in home health utilization has occurred despite limited evidence about the necessary volume of HHC to achieve optimal patient outcomes and whether it substitutes for more costly institutional care. Little is known about integrating HHC with care in other settings to reduce overall health care costs. The central hypotheses of this study are: volume-outcome relationships are present in HHC for common patient conditions; upper- and lower-volume thresholds exist that define the range of services most beneficial to patients; and a strengthened physician role and better integration of HHC with other services during an episode of care can optimize patient outcomes while controlling costs. To test these hypotheses, a total of 3,600 patient records will be selected from a nationally representative sample of home health agencies. Trained data collectors at each agency will record patient health status and service information between HHC admission and discharge to assess patient outcomes and costs within the HHC episode. Long-term, self-reported outcomes will be assessed from telephone interview data at HHC admission and from 6-month followups. These primary data concerning patient status and outcomes will be combined with Medicare claims data over the episode of care to assess the relationship between service volume in HHC and in both patient outcomes and costs. Analyses of data relating to physician involvement and the sequence of use of other providers will address issues of integration with other services.

Status: This project is in the developmental phase.

89-035 Medicare Alzheimer's Disease Demonstration: Amherst H. Wilder Foundation

Project No.:	95-P-60007
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Robert Held
Awardee:	Amherst H. Wilder Foundation 919 La Fond Avenue St. Paul, MN 55104

HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project is to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care are being studied. Both models include case management and a wide range of services not presently covered by Medicare such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models are differentiated by the level and intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that can be paid for by Medicare each month. Eight organizations were selected to participate. Model A sites have a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflect geographic cost variations. Model A sites are in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites is 1:30 and their monthly payment limits are between $580 and $699. Model B sites are located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: Under its original authorization, the project was scheduled to end in May 1992. However, it has been extended twice by congressional legislation. A provision in the Omnibus Budget Reconciliation Act of 1990 continued the demonstration for 1 year. It also increased the funding for the project's administrative and service costs from $40 million to $55 million and for the evaluation from $2 million to $3 million. The demonstration was later extended by the Omnibus Budget Reconciliation Act of 1993. This legislation provided another $3 million for administration and service and an additional $2 million for the evaluation, which is being conducted by the University of California, San Francisco (UCSF). Technical assistance and training also has been provided to the sites by UCSF throughout the duration of the project. The demonstration is scheduled to end in November 1994.

89-036 Medicare Alzheimer's Disease Demonstration: Carle Clinic

Project No.:	95-P-60008
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Cheryl Schraeder, Ph.D.
Awardee:	Carle Clinic Association 307 East Oak, Suite 3 P.O. Box 718 Mahomet, IL 61853
HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project is to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care are being studied. Both models include case management and a wide range of services not presently covered by Medicare such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models are differentiated by the level and intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that can be paid for by Medicare each month. Eight organizations were selected to participate. Model A sites have a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflect geographic cost variations. Model A sites are in Memphis, Tennessee;

Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites is 1:30 and its monthly payment limits are between $580 and $699. Model B sites are located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: Under its original authorization, the project was scheduled to end in May 1992. However, it has been extended twice by congressional legislation. A provision in the Omnibus Budget Reconciliation Act of 1990 continued the demonstration for 1 year. It also increased the funding for the project's administrative and service costs from $40 million to $55 million and for the evaluation from $2 million to $3 million. The demonstration was later extended by the Omnibus Budget Reconciliation Act of 1993. This legislation provided another $3 million for administration and service costs and an additional $2 million for the evaluation, which is being conducted by the University of California, San Francisco (UCSF). Technical assistance and training also has been provided to the sites by UCSF throughout the duration of the project. The demonstration is scheduled to end in November 1994.

89-037 Medicare Alzheimer's Disease Demonstration: Cincinnati Area Senior Services, Inc.

Project No.:	95-P-60002
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Beth Patterson
Awardee:	Cincinnati Area Senior Services, Inc. 644 Linn Street, Suite 1017 Cincinnati, OH 45203
HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project is to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care are being studied. Both models include case management and a wide range of services not presently covered by Medicare such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models are differentiated by the level and intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that can be paid for by Medicare each month. Eight organizations were selected to participate. Model A sites have a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflect geographic cost variations. Model A sites are in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites is 1:30 and its monthly payment limits are between $580 and $699. Model B sites are located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: Under its original authorization, the project was scheduled to end in May 1992. However, it has been extended twice by congressional legislation. A provision in the Omnibus Budget Reconciliation Act of 1990 continued the demonstration for 1 year. It also increased the funding for the project's administrative and service costs from $40 million to $55 million and for the evaluation from $2 million to $3 million. The demonstration was later extended by the Omnibus Budget Reconciliation Act of 1993. This legislation provided another $3 million for administration and service costs and an additional $2 million for the evaluation, which is being conducted by the University of California, San Francisco (UCSF). Technical assistance and training also has been provided to the sites by UCSF throughout the duration of the project. The demonstration is scheduled to end in November 1994.

89-038 Medicare Alzheimer's Disease Demonstration: Good Samaritan Hospital and Medical Center

Project No.:	95-P-60001
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Elizabeth Baxter

Awardee:	Good Samaritan Hospital and Medical Center 1015 Northwest 22nd Avenue Portland, OR 97210
HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project is to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care are being studied. Both models include case management and a wide range of services not presently covered by Medicare such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models are differentiated by the level and intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that can be paid for by Medicare each month. Eight organizations were selected to participate. Model A sites have a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflect geographic cost variations. Model A sites are in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites is 1:30 and its monthly payment limits are between $580 and $699. Model B sites are located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: Under its original authorization, the project was scheduled to end in May 1992. However, it has been extended twice by congressional legislation. A provision in the Omnibus Budget Reconciliation Act of 1990 continued the demonstration for 1 year. It also increased the funding for the project's administrative and service costs from $40 million to $55 million and for the evaluation from $2 million to $3 million. The demonstration was later extended by the Omnibus Budget Reconciliation Act of 1993. This legislation provided another $3 million for administration and service costs and an additional $2 million for the evaluation, which is being conducted by the University of California, San Francisco (UCSF). Technical assistance and training also has been provided to the sites by UCSF throughout the duration of the project. The demonstration is scheduled to end in November 1994.

89-039 Medicare Alzheimer's Disease Demonstration: Miami Jewish Home and Hospital for the Aged

Project No.:	95-P-60005
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Betsy Pegelow
Awardee:	Miami Jewish Home and Hospital for the Aged 151 Northeast 52nd Street Miami, FL 33137
HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project is to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care are being studied. Both models include case management and a wide range of services not presently covered by Medicare such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models are differentiated by the level and intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that can be paid for by Medicare each month. Eight organizations were selected to participate. Model A sites have a case manager to

beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflect geographic cost variations. Model A sites are in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites is 1:30 and its monthly payment limits are between $580 and $699. Model B sites are located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: Under its original authorization, the project was scheduled to end in May 1992. However, it has been extended twice by congressional legislation. A provision in the Omnibus Budget Reconciliation Act of 1990 continued the demonstration for 1 year. It also increased the funding for the project's administrative and service costs from $40 million to $55 million and for the evaluation from $2 million to $3 million. The demonstration was later extended by the Omnibus Budget Reconciliation Act of 1993. This legislation provided another $3 million for administration and service costs and an additional $2 million for the evaluation, which is being conducted by the University of California, San Francisco (UCSF). Technical assistance and training also has been provided to the sites by UCSF throughout the duration of the project. The demonstration is scheduled to end in November 1994.

89-040 **Medicare Alzheimer's Disease Demonstration: Monroe County Long Term Care Program, Inc.**

Project No.:	95-P-60006
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Gerald Eggert, Ph.D.
Awardee:	Monroe County Long Term Care Program, Inc. 349 West Commercial Street, Suite 2250 Piano Works East Rochester, NY 14445
HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project is to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care are being studied. Both models include case management and a wide range of services not presently covered by Medicare such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models are differentiated by the level and intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that can be paid for by Medicare each month. Eight organizations were selected to participate. Model A sites have a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflect geographic cost variations. Model A sites are in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites is 1:30 and its monthly payment limits are between $580 and $699. Model B sites are located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: Under its original authorization, the project was scheduled to end in May 1992. However, it has been extended twice by congressional legislation. A provision in the Omnibus Budget Reconciliation Act of 1990 continued the demonstration for 1 year. It also increased the funding for the project's administrative and service costs from $40 million to $55 million and for the evaluation from $2 million to $3 million. The demonstration was later extended by the Omnibus Budget Reconciliation Act of 1993. This legislation provided another $3 million for administration and service costs and an additional $2 million for the evaluation, which is being conducted by the University of California, San Francisco (UCSF). Technical assistance and training also has been provided to the sites by UCSF throughout the

duration of the project. The demonstration is scheduled to end in November 1994.

89-041 Medicare Alzheimer's Disease Demonstration: Northeast Alzheimer's Consortium

Project No.:	95-P-60003
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Glen Gunnels
Awardee:	Northeast Alzheimer's Consortium 1330 Sycamore View, Suite 2 Memphis, TN 38314
HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project is to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care are being studied. Both models include case management and a wide range of services not presently covered by Medicare such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models are differentiated by the level and intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that can be paid for by Medicare each month. Eight organizations were selected to participate. Model A sites have a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflect geographic cost variations. Model A sites are in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites is 1:30 and its monthly payment limits are between $580 and $699. Model B sites are located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: Under its original authorization, the project was scheduled to end in May 1992. However, it has been extended twice by congressional legislation. A provision in the Omnibus Budget Reconciliation Act of 1990 continued the demonstration for 1 year. It also increased the funding for the project's administrative and service costs from $40 million to $55 million and for the evaluation from $2 million to $3 million. The demonstration was later extended by the Omnibus Budget Reconciliation Act of 1993. This legislation provided another $3 million for administration and service costs and an additional $2 million for the evaluation, which is being conducted by the University of California, San Francisco (UCSF). Technical assistance and training also has been provided to the sites by UCSF throughout the duration of the project. The demonstration is scheduled to end in November 1994.

89-042 Medicare Alzheimer's Disease Demonstration: Wood County Senior Citizens Association, Inc.

Project No.:	95-P-60004
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Brenda Wamsley
Awardee:	Wood County Senior Citizens Association, Inc. 925 Market Street Parkersburg, WV 26101
HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project is to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and

related disorders. Two models of care are being studied. Both models include case management and a wide range of services not presently covered by Medicare such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models are differentiated by the level and intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that can be paid for by Medicare each month. Eight organizations were selected to participate. Model A sites have a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflect geographic cost variations. Model A sites are in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites is 1:30 and its monthly payment limits are between $580 and $699. Model B sites are located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: Under its original authorization, the project was scheduled to end in May 1992. However, it has been extended twice by congressional legislation. A provision in the Omnibus Budget Reconciliation Act of 1990 continued the demonstration for 1 year. It also increased the funding for the project's administrative and service costs from $40 million to $55 million and for the evaluation from $2 million to $3 million. The demonstration was later extended by the Omnibus Budget Reconciliation Act of 1993. This legislation provided another $3 million for administration and service costs and an additional $2 million for the evaluation, which is being conducted by the University of California, San Francisco (UCSF). Technical assistance and training also has been provided to the sites by UCSF throughout the duration of the project. The demonstration is scheduled to end in November 1994.

89-054 **Multistate Nursing Home Case-Mix and Quality Demonstration: Kansas** (Formerly, The Multistate Nursing Home Case-Mix and Quality Demonstration)

Project No.:	11-C-99366/7
Period:	June 1989–June 1995
Funding:	$ 1,544,755
Award:	Cooperative Agreement
Principal Investigator:	Jan Allen
Awardee:	Kansas Department of Social and Rehabilitative Services Adult Services Commission—Adult Care Home Program West Hall 300 SW. Oakley Street Topeka, KS 66606
HCFA Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: This project builds on past and current initiatives with nursing home case-mix payment and quality assurance. The 6-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid nursing home resident classification and payment system in Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care planning, payment classification, and quality monitoring systems. The project consists of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project has conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct care staff time across the States is 115 minutes per day per resident. A new patient classification system and a Multistate Medicare/Medicaid Payment Index containing 44 groups has been created. A 35-group variation was approved in January 1993 for the Medicaid portion in Mississippi and South Dakota. The variation collapses the 12 rehabilitation groups into 3 groups for Medicaid purposes. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. The States have collected and reviewed over 600,000 MDS+ documents on over 200,000 different residents assessed between September 1990 and July 1993. In preparation for developing the payment systems, the resident characteristic data and facility cost reports have been analyzed to determine the case mix of residents and patterns of service utilization. Kansas has implemented its Medicaid payment system. The Medicare case-mix-adjusted payment system will be implemented in early 1995. The quality monitoring information system has been pilot-tested, and 30 quality indicators have been developed for facility-level and resident-level quality monitoring.

89-055 **Multistate Nursing Home Case-Mix and Quality Demonstration: Maine** (Formerly, The Multistate Nursing Home Case-Mix and Quality Demonstration)

Project No.:	11-C-99363/1
Period:	June 1989–June 1995
Funding:	$ 1,091,274
Award:	Cooperative Agreement
Principal Investigator:	Andrew Coburn, Ph.D.
Awardee:	Maine Department of Human Services Bureau of Medical Services State House Station No. 11 Augusta, ME 04333
HCFA Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: This project builds on past and current initiatives with nursing home case-mix payment and quality assurance. The 6-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid nursing home resident classification and payment system in Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care planning, payment classification, and quality monitoring systems. The project consists of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project has conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct care staff time across the States is 115 minutes per day per resident. A new patient classification system and a Multistate Medicare/Medicaid Payment Index containing 44 groups has been created. A 35-group variation was approved in January 1993 for the Medicaid portion in Mississippi and South Dakota. The variation collapses the 12 rehabilitation groups into 3 groups for Medicaid purposes. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. The States have collected and reviewed over 600,000 MDS+ documents on over 200,000 different residents assessed between September 1990 and July 1993. In preparation for developing the payment systems, the resident characteristic data and facility cost reports have been analyzed to determine the case mix of residents and patterns of service utilization. Maine began implementing its Medicaid payment system on October 1, 1993. The Medicare case-mix-adjusted payment system will be implemented in early 1995. The quality monitoring information system has been pilot-tested, and 30 quality indicators have been developed for facility-level and resident-level quality monitoring.

89-056 **Multistate Nursing Home Case-Mix and Quality Demonstration: Mississippi** (Formerly, The Multistate Nursing Home Case-Mix and Quality Demonstration)

Project No.:	11-C-99362/4
Period:	June 1989–November 1994
Funding:	$ 1,572,289
Award:	Cooperative Agreement
Principal Investigator:	Jamie L. Collier
Awardee:	Office of Governor Division of Medicaid Robert E. Lee Building, Suite 801 239 North Lamar Street Jackson, MS 39201
HCFA Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: This project builds on past and current initiatives with nursing home case-mix payment and quality assurance. The 6-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid nursing home resident classification and payment system in Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care planning, payment classification, and quality monitoring systems. The project consists of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project has conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct care staff time across the States is 115 minutes per day per resident. A new patient classification system and a Multistate Medicare/Medicaid Payment Index containing 44 groups has been created. A 35-group variation was approved in January 1993 for the

Medicaid portion in Mississippi and South Dakota. The variation collapses the 12 rehabilitation groups into 3 groups for Medicaid purposes. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. The States have collected and reviewed over 600,000 MDS+ documents on over 200,000 different residents assessed between September 1990 and July 1993. In preparation for developing the payment systems, the resident characteristic data and facility cost reports have been analyzed to determine the case mix of residents and patterns of service utilization. In July 1993 Mississippi implemented its Medicaid case-mix systems statewide. The Medicare case-mix-adjusted payment system will be implemented in early 1995. The quality monitoring information system has been pilot-tested, and 30 quality indicators have been developed for facility-level and resident-level quality monitoring.

89-057 **Multistate Nursing Home Case-Mix and Quality Demonstration: South Dakota** (Formerly, The Multistate Nursing Home Case-Mix and Quality Demonstration)

Project No.:	11-C-99367/8
Period:	June 1989–November 1995
Funding:	$ 1,114,623
Award:	Cooperative Agreement
Principal Investigator:	Carol Job, R.N.
Awardee:	South Dakota Department of Social Services Office of Adult Services and Aging 700 Governors Drive Pierre, SD 57501
HCFA Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: This project builds on past and current initiatives with nursing home case-mix payment and quality assurance. The 6-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid nursing home resident classification and payment system in Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care planning, payment classification, and quality monitoring systems. The project consists of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project has conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct care staff time across the States is 115 minutes per day per resident. A new patient classification system and a Multistate Medicare/Medicaid Payment Index containing 44 groups has been created. A 35-group variation was approved in January 1993 for the Medicaid portion in Mississippi and South Dakota. The variation collapses the 12 rehabilitation groups into 3 groups for Medicaid purposes. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. The States have collected and reviewed over 600,000 MDS+ documents on over 200,000 different residents assessed between September 1990 and July 1993. In preparation for developing the payment systems, the resident characteristic data and facility cost reports have been analyzed to determine the case mix of residents and patterns of service utilization. In July 1993 South Dakota implemented its Medicaid case-mix systems statewide. The Medicare case-mix-adjusted payment system will be implemented in early 1995. The quality monitoring information system has been pilot-tested, and 30 quality indicators have been developed for facility-level and resident-level quality monitoring.

93-048 **National Health Interview Survey Disability Supplement: 1994–95** (Formerly, A 1994/1995 National Health Interview Survey Disability Supplement)

Project No.:	HCFA-IA-9362
Period:	June 1993–June 1994
Award:	Interagency Agreement
Principal Investigator:	Owen Thornberry
Awardee:	Centers for Disease Control National Center for Health Statistics 6325 Belcrest Road, Room 850 Hyattsville, MD 20782
HCFA Project Officer:	Elizabeth Mauser, Ph.D. Division of Long-Term Care Experimentation

Description: The Health Care Financing Administration's (HCFA) transfer of funds to the National Center for Health Statistics is in support of the implementation of the 1994/1995 disability survey as a supplement to the National Health Interview Survey. Although HCFA provides extensive support for the disabled through the Medicare and Medicaid programs, very little is known about this population. The National Health Interview

Survey Disability Supplement (NHISDS) will be the first survey on the disabled in 15 years. The NHISDS will be conducted during calendar years 1994 and 1995, with approximately 250,000 people of the 96,000 sampled households. The survey will consist of two phases:

- Phase I will screen the relevant populations and will collect basic descriptive information.
- Phase II will obtain information on all household members who experience limitations caused by a health condition.

Data from Phase I will be used to make estimates of the prevalence of disability and to determine eligibility for Phase II questionnaires. In Phase II, separate questionnaires will be given to adult and child respondents. This survey will be the first source of information to determine the size, characteristics, service use, and out-of-pocket costs for individuals with mental retardation and related conditions. The survey of children will provide information on the number, characteristics, severity, and effects on families of children with disabilities. This survey will collect information on income and assets, along with basic disability information, to better understand the characteristics of actual and potential Supplemental Security Income recipients. The information gathered from the NHISDS will be crucial for addressing a broad number of HCFA policy concerns affecting persons with disabilities.

Status: Questionnaires for the disability supplement have been revised. Phase I interviews began in January 1994 and Phase II adult and children interviews began during summer 1994.

94-114 National Minority Historically Black Colleges and Universities Health Education Initiative

Project No.:	HCFA-IA-4105
Period:	September 1994–September 1996
Funding:	$ 200,000
Award:	Intra-agency Agreement with the Centers for Disease Control and Prevention
Principal Investigator:	Dorothy G. Moore
Awardee:	National Association for Equal Opportunity in Higher Education Black Higher Education Center Lovejoy Building 400 12th Street, NE. Washington, DC 20002
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: The purpose of this intra-agency agreement is for the Health Care Financing Administration (HCFA) to provide financial support to the Centers for Disease Control (CDC) in support of an existing CDC cooperative agreement with the National Association for Equal Opportunity (NAFEO) in Higher Education. This endeavor includes 117 historically black colleges and universities (HBCU) participating in the implementation of an human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) education program. This effort will focus on implementation of a model program to provide HIV/AIDS education, prevention, and information on eligibility criteria for the Medicaid program for students and faculty of the 117 HBCUs. The objective is to integrate prevention activities into curricular and non-curricular programs. In addition, the HBCUs shall, in conjunction with NAFEO, develop a student pamphlet on State-level Medicaid eligibility criteria and coverage policy for minority persons with HIV/AIDS. This pamphlet should explain the criteria for defining HIV/AIDS disability for purposes of establishing eligibility for participation in the Medicaid program for each HBCU's home State and for identifying the State agency that is responsible for making disability determinations. The pamphlet also should explain the mandatory and optional services available to Medicaid eligible minority persons with AIDS. A final report prepared by NAFEO will synthesize and integrate the results of the Medicaid eligibility criteria and coverage policies of each State for every participating HBCU. This report shall include an issue paper on the topic of health systems reform as it might affect Medicaid eligibility for persons with AIDS. Included also will be: clarification and specification of the major issues or questions regarding health care system reform, financing, delivery, and quality of care among minority persons with AIDS; a review of the published literature on the subject; a description of any additional barriers to health care services faced by black persons or other minority people with AIDS; and the development of alternative courses of action in the context of the objective of State-level health care system reform and an assessment of the feasibility for implementating the proposed alternatives.

Status: The project is in its developmental stage.

94-113 National Recurring Data Set Project: Ongoing National State-by-State Data Collection and Policy/Impact Analysis on Residential Services for Persons with Developmental Disabilities

Project No.:	HCFA-IA-9485
Period:	September 1994–September 1995
Funding:	$ 25,000

Award:	Intra-Agency Agreement with the Administration on Developmental Disabilities
Principal Investigator:	Charlie Lakin, Ph.D.
Awardee:	The University of Minnesota Institute of Community Integration 150 Pillsbury Drive, SE. Minneapolis, MN 55455
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: This intra-agency agreement will support secondary data analyses and the production of a report that describes and updates the status of persons with mental retardation and related conditions (MR/RC) in institutional care facilities for the mentally retarded (ICF/MR), Medicaid waiver programs, and nursing homes funded under the Medicaid program to assist in the evaluation of Medicaid services for persons with MR/RCs and to point out areas in need of reform. The report will include:

- Background description of the key Medicaid programs of interest.
- State-by-State and national statistics on ICF/MRs, Medicaid home and community-based services, and nursing home utilization.
- Description of the characteristics of ICF/MRs and their residents, with comparative statistics for noncertified facilities.

Status: The project is in its developmental stage.

90-019 New York Case-Mix Payment and Quality Demonstration

Project No.:	95-C-99540/2
Period:	May 1990–June 1996
Funding:	$ 981,718
Award:	Cooperative Agreement
Principal Investigator:	Steven C. Anderman
Awardee:	New York State Department of Health Empire State Plaza Room 1683 Corning Tower Albany, NY 12237
HCFA Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: New York State will participate in The Multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration. The objective of the demonstration is to test the feasibility and cost effectiveness of a case-mix payment system for nursing facility services under the Medicare and Medicaid programs that are based on a common patient classification system. The addition of New York State enhances the Health Care Financing Administration's ability to project the results of the demonstration on a national basis. New York represents a heavily regulated, northern industrialized area with larger, high-cost nursing facilities that are medically sophisticated and highly skilled. Sixteen percent of the national Medicare skilled nursing facility days are incurred in New York State. New York is uniquely suited for inclusion because it already has implemented a complementary system for its Medicaid nursing facility payment program.

Status: In early 1991, project staff completed the minimum data set field test in 25 facilities on 993 residents. These data have been added to the data base and analyzed to develop the new NHCMQ Medicare/Medicaid classification system. The inclusion of the New York State data has resulted in the addition of a very high rehabilitation group to the upper end of the classification. The State has implemented the minimum data set plus statewide as its resident assessment instrument. In November 1992 the New York State began receiving the information monthly from all facilities; by October 1, 1993, it had received a total of 397,040 assessments. The State has conducted analyses of 1990 Medicare Cost Report data and Medicare provider analysis and review Part A skilled nursing facility stay data. The New York patient review instrument data also were used in estimating the average facility case mix for the design of the Medicare case-mix payment system. The Medicare portion is expected to become operational in early 1995.

90-060 Nurse Practitioner/Physician Assistant Aggregate Visit Demonstration

Project No.:	95-C-99625/1
Period:	September 1990–September 1993
Funding:	$ 130,538
Award:	Cooperative Agreement
Principal Investigator:	Jeffrey L. Kang
Awardee:	The Urban Medical Group 545 D Centre Street Jamaica Plain, MA 02130
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation

Mandate: Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: Under section 6114(e) of Public Law 101-239, the Medicare program provides Part B coverage to nursing home residents for medical visits rendered by nurse practitioners who are members of a physician/physician assistant/nurse practitioner team. Under this legislation, the number of visits supplied to any nursing home patient is limited to an average of 1.5 visits per month. Section 6114(e) mandates a demonstration project under which the visit limitation would be applied on an average basis over the aggregate total of residents receiving services from members of the provider team. A preliminary Massachusetts demonstration project, Case-Managed Medical Care for Nursing Home Patients, used nurse practitioners and physician assistants to provide visits to nursing home patients. This project ended on September 30, 1990. Many of the original Massachusetts demonstration sites are participating in this second demonstration project.

Status: This project was conducted in two phases. The first (primarily involving planning and development activities) was completed in March 1992. The second, which included the actual implementation and operation, was completed in March 1993. Although negotiations with the Medicare carrier, Massachusetts Blue Cross and Blue Shield, were concluded during the first phase, the grantee has experienced a great deal of difficulty in securing usable/clean data. A 6-month no-cost extension of the grant (until September 29, 1993) was provided. However, as Massachusetts Blue Cross and Blue Shield was unable to provide corrected data until spring 1994, the final report is not expected until fall 1994.

84-008 **On Lok's Risk-Based Community Care Organization for Dependent Adults: California Department of Health Services** (Formerly, On Lok's Risk-Based Community Care Organization for Dependent Adults)

Project No.: 11-P-98334
Period: November 1983-Indefinite
Funding: Waiver only
Award: Grant
Principal Investigator: Louise Nava
Awardee: California Department of Health Services
714/744 P Street
P.O. Box 942732
San Francisco, CA 94234-7320

HCFA Project Officer: Stefan N. Miller
Division of Long-Term Care Experimentation

Mandates: Social Security Amendments of 1983 (Public Law 98-21)
Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)

Description: As mandated by sections 603(c)(1) and (2) of Public Law 98-21, the Health Care Financing Administration granted Medicare waivers to On Lok Senior Health Services and Medicaid waivers to the California Department of Health Services. Together these waivers permitted On Lok to implement an at-risk, capitated payment demonstration in which more than 300 frail elderly persons, certified by the California Department of Health Services for institutionalization in a skilled nursing facility, are provided a comprehensive array of health and health-related services in the community. The current demonstration maintains On Lok's comprehensive community-based program, but has modified its financial base and reimbursement mechanism. All services are paid for by a predetermined capitated rate from both the Medicare and Medicaid (Medi-Cal) programs. The Medicare rate is based on the average per capita cost for the San Francisco county Medicare population. The Medi-Cal rate is based on the State's computation of current costs for similar Medi-Cal recipients, using the formula for prepaid health plans. Individual participants may be required to make copayments, spend down income, or divest assets based on their financial status and eligibility for either or both programs. On Lok has accepted total risk beyond the capitated rates of both Medicare and Medi-Cal with the exception of the Medicare payment for end stage renal disease. The demonstration provides service funding only under the waivers. Research and development activities are funded through private foundations.

Status: Section 9220 of Public Law 99-272 has extended On Lok's Risk-Based Community Care Organization for Dependent Adults indefinitely, subject to the terms and conditions in effect as of July 1, 1985, with the exception of the requirements relating to data collection and evaluation.

84-001 **On Lok's Risk-Based Community Care Organization for Dependent Adults: On Lok Senior Health Services** (Formerly, On Lok's Risk-Based Community Care Organization for Dependent Adults)

Project No.: 95-P-98246
Period: November 1983–Indefinite

Funding:	Waiver only
Award:	Grant
Principal Investigator:	Sue Wong
Awardee:	On Lok Senior Health Services 1333 Bush Street San Francisco, CA 94109
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Social Security Amendments of 1983 (Public Law 98-21) Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)

Description: As mandated by sections 603(c)(1) and (2) of Public Law 98-21, the Health Care Financing Administration granted Medicare waivers to On Lok Senior Health Services and Medicaid waivers to the California Department of Health Services. Together these waivers permitted On Lok to implement an at-risk, capitated payment demonstration in which more than 300 frail elderly persons, certified by the California Department of Health Services for institutionalization in a skilled nursing facility, are provided a comprehensive array of health and health-related services in the community. The current demonstration maintains On Lok's comprehensive community-based program, but has modified its financial base and reimbursement mechanism. All services are paid for by a predetermined capitated rate from both the Medicare and Medicaid (Medi-Cal) programs. The Medicare rate is based on the average per capita cost for the San Francisco county Medicare population. The Medi-Cal rate is based on the State's computation of current costs for similar Medi-Cal recipients, using the formula for prepaid health plans. Individual participants may be required to make copayments, spend down income, or divest assets based on their financial status and eligibility for either or both programs. On Lok has accepted total risk beyond the capitated rates of both Medicare and Medi-Cal with the exception of the Medicare payment for end stage renal disease. The demonstration provides service funding only under the waivers. Research and development activities are funded through private foundations.

Status: Section 9220 of Public Law 99-272 has extended On Lok's Risk-Based Community Care Organization for Dependent Adults indefinitely, subject to the terms and conditions in effect as of July 1, 1985, with the exception of the requirements relating to data collection and evaluation. During the past year, On Lok expanded its services by opening a state-of-the-art adult day health center in the heart of its enrollee base.

90-017 Policy Study of the Cost Effectiveness of Institutional Subacute Care Alternatives and Services: 1984–92

Project No.:	18-C-99491/8
Period:	May 1990–January 1995
Funding:	$ 1,427,400
Award:	Cooperative Agreement
Principal Investigator:	Andrew Kramer, M.D.
Awardee:	University of Colorado Health Sciences Center 1355 South Colorado Boulevard Denver, CO 80222
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The University of Colorado will assess which subacute institutional settings and combinations of services are most cost-effective and provide more positive outcomes for various types of patients. Researchers will identify potential Health Care Financing Administration (HCFA) policy changes that might encourage use of the most appropriate settings and services. This project will use primary and secondary data from three previous HCFA-sponsored studies to compare quality, cost effectiveness, case mix, service mix, and utilization among institutional subacute care alternatives (e.g., skilled nursing facilities and rehabilitation hospitals) within and between two time periods: 1984–87 and 1990–92; the longitudinal admission sample is for the period 1992–94. This methodology is designed to determine the most cost-effective combinations of services and provider settings for various types of patients requiring subacute care (i.e., stroke and hip fracture). Functional-related groups and alternative groupings will be tested to explain variation in resource consumption. Several prospective and per case payment methods for selected types of subacute care will be modeled.

Status: Cross-sectional and longitudinal data collection started in October 1991. By May 1993, 160 facilities had been recruited and visited. Of these facilities, 117 are participating in the longitudinal component. The sample from these 160 facilities includes 1,410 Medicare patients and 1,040 non-Medicare patients, totaling 2,450 patients. A report on cross-sectional analyses is expected in October 1994 and the report on longitudinal analyses is expected in January 1995.

92-100 **Potential of Coordinated Care Targeted to Medicare Beneficiaries with Medicaid Coverage** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/33
Period:	April 1992–August 1992
Funding:	$ 18,500
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The purpose of this paper was to discuss the potential for coordinating health service delivery and financing among the population eligible for both Medicare and Medicaid financing (the "dual eligibles"). First, it discussed the interactions between Medicare and Medicaid eligibility and financing for services and then presented a description of the characteristics and health service utilization of the dual eligibles. Second, it explored the potential benefits of care coordination and management among this population and addressed lessons learned and relevant issues in developing coordinated care targeted to the dual eligibles. Lisa Alecxih of Lewin/VHI, Inc., was the lead analyst.

Status: This paper found that, although dual eligibles typically use high amounts of both Medicare and Medicaid services (where Medicaid primarily funds chronic care services among Medicare beneficiaries), there is very little coordination between the two programs. Dual eligibles tend to be poor females living in the community. Nearly one-third of the noninstitutionalized Medicare beneficiaries under 65 years of age also are receiving Medicaid. The final report will be sent to the National Technical Information Service.

94-085 **Predictors of Access and Effects of Medicare Post-Hospital Care for Beneficiaries 65 Years of Age or Over**

Project No.:	17-C-90395/3
Period:	September 1994–September 1996
Funding:	$ 502,614
Award:	Cooperative Agreement
Principal Investigator:	David L. Rabin, Ph.D.
Awardee:	Georgetown University Division of Community Health Studies and Family Medicine 3750 Reservoir Road, NW. Washington, DC 20007-2197
HCFA Project Officer:	Carolyn Rimes Division of Long-Term Care Experimentation

Description: As a consequence of regulatory and legislative changes in the late 1980s, Medicare post-hospital care (PHC) has become the most rapidly growing Medicare expenditure. PHC consists of home health care, inpatient skilled nursing facility care, and rehabilitation hospital care. The growth in use, changes in eligibility requirements, and the increase in Medicare costs have raised questions about equal access and the effects of PHC use. The literature on PHC suggests two important trends. A few Medicare prospective payment inpatient hospital diagnosis-related groups (DRG) account for most PHC, but within these DRGs large variations exist in use. Personal health, economic, socio-demographic and household factors as well as area and health system characteristics are predictive of the use of PHC despite equal access under the Medicare program. This study uses the Medicare Current Beneficiary Survey to investigate three major research objectives:

- Describe the personal, area, and health system characteristics of users and those of similar persons with unmet needs for PHC in order to assess differences by gender, race, and income class and the potential for substitution of care modes.
- Study the longitudinal effects of PHC on Medicare program costs and rehospitalization.
- Study the personal health effects associated with PHC.

Status: This project is in the developmental phase.

90-003 **Program of All-Inclusive Care for the Elderly: Beth Abraham Hospital** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99361
Period:	October 1989–January 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Susan Aldrich
Awardee:	Beth Abraham Hospital 612 Allerton Avenue Bronx, NY 10467

HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: During this year, a second adult day health center was opened in one of Beth Abraham's Housing and Urban Development 202 buildings. Plans have begun to expand the service area to lower Westchester County and to Manhattan.

92-005 **Program of All-Inclusive Care for the Elderly: Bienvivir Senior Health Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99649
Period:	December 1991–May 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Rosemary Castillo
Awardee:	Bienvivir Senior Health Services 6000 Welch, Suite A-2 El Paso, TX 77905-1753
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as

stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: This is the first year of operations under both Medicare and Medicaid waivers. During the first 2 years, Bienvivir Senior Health Services was operating under Medicaid-only waivers. The next year of operation will be at full financial risk.

94-061 **Program of All-Inclusive Care for the Elderly: California Department of Health Services**

Project No.:	11-P-90485
Period:	May 1994–April 1997 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Louise Nava
Awardee:	California Department of Health Services 714/744 P Street P.O. Box 942732 Sacramento, CA 94234-7320
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: This is the initial year under Medicare and Medicaid waivers for the site.

91-066 **Program of All-Inclusive Care for the Elderly: Colorado Department of Social Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99646
Period:	August 1991–September 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Donna Marshall
Awardee:	Colorado Department of Social Services 1575 Sherman Street Denver, CO 80203-1714
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of

care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: The State and the site continue to discuss alternative methods of capitation formulation.

90-045 **Program of All-Inclusive Care for the Elderly: Community Care Organization** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99628
Period:	August 1990–October 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Kirby G. Shoaf
Awardee:	Community Care Organization 5228 West Fond du Lac Avenue Milwaukee, WI 53216
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: The site is examining the possibility of developing a third adult day health center and is considering an associated housing option. A transportation feasibility study, completed in 1994, indicated that the site could benefit substantially by operating its own transportation service. As a result, it began transporting enrollees via site-owned vans in March and has witnessed a 50-percent reduction in transportation costs.

92-101 **Program of All-Inclusive Care for the Elderly Data Management**

Project No.:	500-92-0007
Period:	March 1992–March 1995
Funding:	$ 613,014

Award:	Contract
Principal Investigator:	Marleen L. Clark, Ph.D.
Awardee:	On Lok, Inc. 1333 Bush Street San Francisco, CA 94109
HCFA Project Officer:	Kay Lewandowski Division of Long-Term Care Experimentation

Description: The purpose of this project is to provide continuing data management throughout the Program of All-Inclusive Care for the Elderly (PACE) demonstration period to ensure that a valid, reliable data set is maintained for monitoring project operations and for use by the Health Care Financing Administration's independent evaluator. The PACE demonstration replicates a unique model of managed care service delivery for very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by the participating States. DataPACE maintains a data set on PACE enrollees including demographic and enrollment information, health and functional status, and service utilization. For the PACE demonstration project, On Lok has established a minimum data set and has implemented data collection procedures at the PACE sites for this data set. This data set includes the variables and program information originally designed to be used by evaluators.

Status: The DataPACE software and data management routines have been implemented at all sites. On Lok continues to monitor data quality and provides feedback to the sites. During the second year, progress was made toward rewriting the original Macintosh-based software for Data Operating System-based environments.

90-010 **Program of All-Inclusive Care for the Elderly: East Boston Geriatric Services, Inc.** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99357
Period:	October 1989–May 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Jean Masland
Awardee:	East Boston Geriatric Services, Inc. 10 Gove Street Boston, MA 02128
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: In 1994, East Boston opened its third adult day health center with the capacity to serve a daily census of 50 persons. The second Housing and Urban Development project is continuing and groundbreaking is expected to be completed before the end of 1994.

93-098 **Program of All-Inclusive Care for the Elderly: Illinois Department of Public Aid** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-90236
Period:	April 1993–March 1996 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Melinda Hazelwood
Awardee:	Illinois Department of Public Aid 201 South Grand Avenue East Springfield, IL 62763-0001
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: The site voluntarily withdrew from the PACE demonstration effective April 30, 1994. As a result, the State waiver ended.

90-009 **Program of All-Inclusive Care for the Elderly: Massachusetts State Department of Public Welfare** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99356
Period:	October 1989–May 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Diane Flanders
Awardee:	Massachusetts Department of Public Welfare 180 Tremont Street Boston, MA 02111
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid

coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: The State is hoping to develop six additional PACE sites.

92-033 **Program of All-Inclusive Care for the Elderly: New York State Department of Social Services, March 1992–March 1995** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99357
Period:	March 1992–March 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Christopher Rush
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, NY 12243-0001
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: The State surveyed the site and found it to be in compliance with applicable State and Federal requirements.

90-004 **Program of All-Inclusive Care for the Elderly: New York State Department of Social Services, October 1989–January 1995** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99360
Period:	October 1989–January 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Christopher Rush
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, NY 12243-0001
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: During the year, the State performed a survey of Beth Abraham's program and found it to be in compliance with applicable State and Federal laws and regulations.

90-007 **Program of All-Inclusive Care for the Elderly: Oregon State Department of Human Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99358
Period:	October 1989–May 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Dexter Henderson
Awardee:	Oregon State Department of Human Services 313 Public Service Building Salem, OR 97310
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique

model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: The State is continuing to work with the site on a capitation methodology.

90-008 **Program of All-Inclusive Care for the Elderly: Providence Medical Center** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99359
Period:	October 1989–May 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Don Keister
Awardee:	Providence Medical Center 4805 Northeast Glisan Street Portland, OR 97213
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: This is the first year of full financial risk for Providence Medical Center. The Department of Housing and Urban Development approved a housing project that will make 40 units available and will help defray the cost of furnishing foster care. Foster care is important for this site since over 70 percent of its enrollees live in foster care settings.

90-043 **Program of All-Inclusive Care for the Elderly: Richland Memorial Hospital** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99630
Period:	August 1990–September 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Judy Baskins
Awardee:	Richland Memorial Hospital Fifteen Richland Medical Park Columbia, SC 29203
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided to all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: The Eau Clair adult day health center was relocated to accommodate a larger daily census of enrollees. During summer 1994, the site opened the Northeast Day Health Center to accommodate up to 24 of its dementia enrollees.

92-032 **Program of All-Inclusive Care for the Elderly: Rochester General Hospital** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99660
Period:	March 1992–March 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Kathryn McGuire
Awardee:	Rochester General Hospital 311 Alexander Street Rochester, NY 14604
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term

care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: During the year, the site received conditional approval for a Housing and Urban Development 202 Grant that would provide funds for 55 housing units. The final report by the Center for Governmental Research (a nonprofit Rochester-based organization) was released during the year and was recorded high marks for participant and caregiver satisfaction. It showed that newly enrolled participants experienced a 75-percent reduction in the number of hospital days per person from the pre-PACE year.

90-044 **Program of All-Inclusive Care for the Elderly: South Carolina State Health and Human Services Finance Commission** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99629
Period:	August 1990–September 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Nicki Harvey
Awardee:	South Carolina State Health and Human Services Finance Commission P.O. Box 8206 Columbia, SC 29202-8206
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are: East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: This was the first year in which the site was responsible for assuming full financial risk. It entered the year with a significant financial reserve. To boost its enrollment, the South Carolina Health and Human Services Finance Commission hired a community outreach coordinator to organize a more effective marketing effort.

94-040 **Program of All-Inclusive Care for the Elderly: Sutter Health System**

Project No.:	95-P-90484
Period:	May 1994–April 1997 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Sandy Goss

Awardee:	Sutter Health System 2800 L Street Sacramento, CA 95816
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: This is the Sutter Health Systems's first year of operation under both Medicare and Medicaid waivers. Prior to this year, the site was operating under Medicaid-only waivers.

92-006 **Program of All-Inclusive Care for the Elderly: Texas Department of Human Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99648
Period:	December 1991–November 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Gerardo Cantu
Awardee:	Texas Department of Human Services P.O. Box 149030 (MC-E-601) Austin, TX 78714-9030
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk

progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: Over the past 2 years (1993–94) since the Medicaid-only waivers were awarded, the State has been working very closely with Bienvivir Senior Health Services and has been watching it mature as a PACE site. The State will continue to carry out periodic monitoring reviews and to offer administrative and professional assistance.

91-065 **Program of All-Inclusive Care for the Elderly: Total Longterm Care, Inc.** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99647
Period:	August 1991–September 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Linda Barley
Awardee:	Total Longterm Care, Inc. 3202 West Colfax Denver, CO 80204
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: The site opened a second adult day health center in August 1994 with the capacity to serve 140 enrollees (and can be expanded to serve an additional 50 enrollees). This center was specifically designed to serve Total Longterm Care's dementia enrollee population, which constitutes 84 percent of its total enrollees.

93-036 **Program of All-Inclusive Care for the Elderly: Umoja Care, Inc.** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-90237
Period:	April 1993–March 1996 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Mary Nelson
Awardee:	Umoja Care, Inc. 4501 West Augusta Boulevard Chicago, IL 60651
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation

Mandates: Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)
Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: This site voluntarily withdrew from the PACE demonstration effective April 30, 1994.

90-046 **Program of All-Inclusive Care for the Elderly: Wisconsin State Department of Health and Social Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.: 11-P-99627
Period: August 1990–October 1994 (yearly continuation)
Funding: Waiver only
Award: Grant
Principal Investigator: Cecilia Geis
Awardee: Wisconsin State Department of Health and Social Services
P.O. Box 7850
Madison, WI 53707-7850
HCFA Project Officer: Stefan N. Miller
Division of Long-Term Care Experimentation

Mandates: Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)
Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration which replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided onsite at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided offsite. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: The State continues to support this program.

94-096 **Project Demonstrating and Evaluating Alternative Methods to Assure and Enhance the Quality of Long-Term Care Services for Persons with Developmental Disabilities through Performance-Based Contracts with Service Providers**

Project No.:	11-C-90443/5
Period:	September 1994–September 1997
Funding:	$ 350,000
Award:	Cooperative Agreement
Principal Investigator:	Helen M. Yates
Awardee:	Minnesota Department of Human Services Health Care Administration 44 Lafayette Road St. Paul, MN 55155-3853
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: The purpose of this project is to determine whether and how well the implementation of new approaches to quality assurance, with outcome-based definitions and measures of quality, will replace the input and process measures of quality and in the process contribute to improving the quality of life of persons with developmental disabilities. The Minnesota Department of Human Services will seek Federal authority to waive necessary provisions of the intermediate care facilities for the mentally retarded (ICF-MR) regulations to permit alternative quality assurance mechanisms in selected demonstration, residential, and support service programs. The Department will enter into performance-based contracts with counties and participating ICF-MR providers. These contracts will specify the amount and conditions of reimbursement, requirements for monitoring and evaluation, and expected client-based outcomes. These client-based outcomes will be determined by the client and by the legal representative, if any, and with the assistance of the county case manager and provider. Some desirable outcomes include enhancement of consumer choice and autonomy, employment, and integration into the community. Criteria for measuring participating agency achievement will be drawn from, but not limited to, the outcome standards developed by the National Accreditation Council on Services for Persons with Developmental Disabilities; the "values experiences" of Frameworks for Accomplishment; and the goals established in Personal Futures Plans, Essential Lifestyle, and Person-Centered planning. According to the proposed quality assurance framework, monitoring of individual outcomes will be done jointly among family members, case managers, and other members of the local review team on a quarterly basis.

Status: The award was made to Minnesota Department of Human Services on September 30, 1994. The project is in the developmental stage.

91-081 **Quality Review for the Home Health Agency Prospective Payment Demonstration**

Project No.:	500-91-0096
Period:	September 1991–December 1994
Funding:	$ 1,499,085
Award:	Contract
Principal Investigator:	Alan Jette, Ph.D.
Awardee:	New England Research Institute, Inc. 9 Galen Street Watertown, MA 02172
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: This contract involves quality review of the care provided by home health agencies (HHA) participating in the HHA Prospective Payment Demonstration. The demonstration is testing two alternative methods of paying HHAs on a prospective basis for services furnished under the Medicare program. The prospective payment approaches to be tested include payments per visit by type of discipline (Phase I) and payments per episode of Medicare-covered home health care (Phase II). To assure incentives created under Phase I do not result in the provision of inadequate care to Medicare beneficiaries, the awardee, New England Research Institute, Inc. (NERI), has implemented a quality assurance approach that utilizes patient record reviews for a pertinent sample of Medicare beneficiaries. If potential or actual problems are discovered, the awardee will implement a defined protocol to address the situation.

Status: During the initial year of the contract, NERI staff completed all of the activities related to the start up of the quality assurance plan, including baseline training for nurse reviewers. Throughout the demonstration period, NERI assessed patterns of problems within HHAs that require educational followup or additional medical reviews. As the Phase I demonstration period was completed on September 30, 1994, NERI has completed analysis of its final sample of records.

92-034 **Randomized Controlled Trial of Expanded Medical Care in Nursing Homes for Acute Care Episodes: Monroe County Long-Term Care Program, Inc.** (Formerly, A Randomized Controlled Trial of Expanded Medical Care in Nursing Homes for Acute Care Episodes)

Project No.:	95-C-90151/2
Period:	March 1992–August 1996
Funding:	$ 1,054,007
Award:	Cooperative Agreement
Principal Investigator:	Gerald Eggert, Ph.D.
Awardee:	Monroe County Long Term Care Program, Inc. 349 West Commercial Street, Suite 2250 Piano Works East Rochester, NY 14445
HCFA Project Officer:	Stefan N. Miller Division of Long-Term Care Experimentation

Description: The objective of this demonstration is to develop, implement, and evaluate the effectiveness of expanded medical services to nursing home residents who are undergoing acute illnesses that would ordinarily require hospitalization. The intervention will include many services that are available in acute hospitals and are feasible and safe in nursing homes. These include an initial physician visit, all necessary followup visits, diagnostic and therapeutic services, and additional nursing care (including private duty), if necessary. The major goals are to reduce medical complications and dislocation trauma resulting from hospitalization and to save the expense of hospital care when patients could be managed safely in nursing homes with expanded services.

Status: Basic preparation for the implementation of the demonstration has been completed. The awardee is in the process of developing provider contracts and in negotiating necessary payments with nursing facilities. Implementation is expected in March 1995.

94-131 **Randomized Controlled Trial of Primary and Consumer-Directed Care for Persons with Chronic Illnesses**

Project No.:	95-C-90467/2
Period:	September 1994–September 1997
Funding:	$ 345,243
Award:	Cooperative Agreement
Principal Investigator:	Gerald Eggert, Ph.D.
Awardee:	Monroe County Long Term Care Program, Inc. 349 West Commercial Street, Suite 2250 Piano Works East Rochester, NY 14445
HCFA Project Officer:	Carolyn Rimes Division of Long-Term Care Experimentation

Description: This demonstration will assess differences in outcome for two treatment groups: a consumer-directed group and a case-managed service group. Findings will be compared with a control group that receives no additional services or benefits. Eligibility for participation is determined by residence in the community (at home or in an assisted living setting) and by Medicare coverage with a diagnosis of irreversible dementia or three or more limitations in activities of daily living. In addition, participants must be at risk for hospitalization (i.e., their participation is based on prior use of hospitals or emergency rooms).

Status: This project is in the developmental phase.

93-097 **Regional Variation in Home Health Episode Length and Number of Visits Per Episode** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/38
Period:	July 1993–November 1994
Funding:	$ 168,600
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: A recent Mathematica Policy Research (MPR) study indicates that there is dramatic regional variation in home health episode length and visits rendered per episode. The average length is 78 days nationally, but ranges from 50 days in the West to 100 days in the South. These observations, in turn, raise two basic questions to be addressed in this study: Why does regional variation occur? and What does regional variation mean; does having less care adversely affect patients? This study uses the Medicare claims files, the provider of services file, the area resource file, and the Regional Home Health Intermediary data base to determine the contribution of three sets of factor to regional variation. These sets of factor are: patient

characteristics, supply of home health agencies and staff, and availability of alternatives to home health care. Lewin/VHI's subcontractor, Jennifer Schore of MPR, is the lead analyst.

Status: A draft report has been submitted to the Office of Research and Demonstrations. The final report will be completed in October 1994.

93-035 Rehabilitating Medicare Beneficiaries at Home

Project No.:	95-C-90243/1
Period:	April 1993–April 1994
Funding:	$ 80,000
Award:	Cooperative Agreement
Principal Investigator:	Samuel Scialabba
Awardee:	Wellmark Healthcare Services, Inc. 60 William Street Wellesley, MA 02181
HCFA Project Officer:	Barbara Greenberg, Ph.D. Division of Long-Term Care Experimentation

Description: Wellmark intends to conduct a 2-year Medicare demonstration that will provide beneficiaries with acute rehabilitation services at home as an alternative to more expensive inpatient rehabilitation hospital services. The Health Care Financing Administration has awarded a cooperative agreement to Wellmark to further refine its project design to develop information on specific eligibility and screening criteria for patient enrollment, detailed cost data on the proposed service package, and informed consent policies to adequately inform patients and caregivers of the risks and responsibilities of rehabilitative home care. Medicare waivers will be required to allow Wellmark reimbursement as a prospective payment system-exempt rehabilitation hospital. Fundings for the evaluation will be provided by the Robert Wood Johnson Foundation as part of a national study entitled Evaluation of Innovative Rehabilitation Alternatives and Critical Dimensions of Rehabilitative Care.

Status: The final report has been submitted. A request for Medicare waivers to implement the project is under review. The projected implementation date for this demonstration is January 1995.

94-043 Simulations of Skilled Nursing Facility Payment Options

Project No.:	500-89-0047/44
Period:	January 1994–November 1994
Funding:	$ 79,200
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: This project, conducted in collaboration with the Health Care Financing Administration (HCFA), produces impact estimates for different payment options for the Medicare skilled nursing facility (SNF) benefit. The impacts of alternative SNF payment options are estimated with the use of The Urban Institute's SNF simulation model. This project uses recent 1990–91 SNF cost reports as input data for the simulation model and estimates the distributional effects of various prospective payment options received from HCFA. This work has been subcontracted to Korbin Liu of The Urban Institute.

Status: This project will be completed in November 1994.

93-078 Site Development and Technical Assistance for the Second Generation Social Health Maintenance Organization

Project No.:	500-93-0033
Period:	September 1993–January 1998
Funding:	$ 1,777,189
Award:	Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	The University of Minnesota School of Public Health Institute for Health Services Research D-351 Mayo Memorial Building 420 Delaware Street, SE., Box 197 Minneapolis, MN 55455-0392
HCFA Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation
Mandate:	Section 4207(b)(4) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The Health Care Financing Administration is planning to implement a second generation social health maintenance organization (S/HMO) demonstration in fiscal year 1995. This project will refine targeting and financing methodologies and the benefit design of the current S/HMO demonstration. Under this contract, the University of Minnesota and its subcontractor, the

University of California, San Francisco, will provide technical assistance in site selection, development, implementation, and operation of the second generation model. Organizations participating in the S/HMO II project will offer Medicare beneficiaries the opportunity to receive a wide range of services including prevention and primary care, acute and post-acute care, and long-term care. One distinguishing characteristic of the second generation sites will be an emphasis on geriatric care.

Status: Pre-award site visits were conducted during September 1994. Site selection and project implementation are scheduled for October 1994. The second generation S/HMO demonstration will have a 1-year developmental phase.

84-004 **Social Health Maintenance Organization Project for Long-Term Care: Elderplan, Inc.** (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09101/2
Period:	August 1984–December 1997
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Eli Feldman
Awardee:	Elderplan, Inc. 6323 Seventh Avenue Brooklyn, NY 11220
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation
Mandates:	Deficit Reduction Act of 1984 (Public Law 98-369) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: In accordance with section 2355 of Public Law 98-369, this project was developed and is implementing the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed annual prepaid capitation sum. Four sites have been selected to participate. Of the four S/HMO demonstration sites selected, two are health maintenance organizations that have added long-term care services to their existing service packages and two are long-term care providers that have added acute care service packages. Elderplan is one of the long-term care provider sites that has developed and added an acute care service component.

Status: Elderplan implemented its service delivery network in March 1985. Elderplan utilizes both Medicare and Medicaid waivers. During the first 30 months of operation, Federal and State Governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On three separate occasions, this demonstration has been extended by legislation. Current legislation (Public Law 103-66) extends the demonstration period through December 31, 1997.

84-005 **Social Health Maintenance Organization Project for Long-Term Care: HealthPartners and Ebenezer Society** (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09102/5
Period:	August 1984–December 1997
Funding:	Waiver only
Award:	Grant
Principal Investigator:	George Halvorson
Awardee:	HealthPartners and Ebenezer Society 8100 34th Avenue South Minneapolis, MN 55440-1309
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation
Mandates:	Deficit Reduction Act of 1984 (Public Law 98-369) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: In accordance with section 2355 of Public Law 98-369, this project was developed and is implementing the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a

fixed annual prepaid capitation sum. Four sites have been selected to participate. Of the four S/HMO demonstration sites selected, two are health maintenance organizations (HMO) that have added long-term care services to their existing service packages and two are long-term care providers that have added acute care service packages. HealthPartners and Ebenezer Society (doing business as Seniors Plus) is one of the HMO sites that has developed and added a long-term care component to its service package.

Status: Seniors Plus implemented its service delivery network in March 1985. Seniors Plus utilizes both Medicare and Medicaid waivers. During the first 30 months of operation, Federal and State Governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On three separate occasions, this demonstration has been extended by legislation. Current legislation (Public Law 103-66) extends the demonstration period through December 31, 1997.

84-006 **Social Health Maintenance Organization Project for Long-Term Care: Kaiser Permanente Center for Health Research** (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09103/0
Period:	August 1984–December 1997
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Lucy Nonnenkamp
Awardee:	Kaiser Permanente Center for Health Research 3800 North Kaiser Center Drive Portland, OR 97227-1098
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation
Mandates:	Deficit Reduction Act of 1984 (Public Law 98-369) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: In accordance with section 2355 of Public Law 98-369, this project was developed and is implementing the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed annual prepaid capitation sum. Four sites have been selected to participate. Of the four S/HMO demonstration sites selected, two are health maintenance organizations (HMO) that have added long-term care services to their existing service packages and two are long-term care providers that have added acute care service packages. Kaiser Permanente Center for Health Research (doing business as Medicare Plus II) is one of the HMO sites that has developed and added a long-term care component to its service package.

Status: Medicare Plus II implemented its service delivery network in March 1985. Medicare Plus II utilizes Medicare waivers only. During the first 30 months of operation, the Federal Government shared financial risk with the Oregon site. This risk sharing ended August 31, 1987. On three separate occasions, this demonstration has been extended by legislation. Current legislation (Public Law 103-66) extends the demonstration period through December 31, 1997.

84-007 **Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan** (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09104/9
Period:	August 1984–December 1997
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Sam Ervin
Awardee:	SCAN Health Plan 521 East Fourth Street Long Beach, CA 90802
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation
Mandates:	Deficit Reduction Act of 1984 (Public Law 98-369) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: In accordance with section 2355 of Public Law 98-369, this project was developed and is implementing the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed annual prepaid capitation sum. Four sites have been selected to participate. Of the four S/HMO demonstration sites selected, two are health maintenance organizations that have added long-term care services to their existing service packages and two are long-term care providers that have added acute care service packages. SCAN Health Plan is one of the long-term care provider sites that has developed and added an acute care service component.

Status: SCAN Health Plan implemented its service delivery network in March 1985. SCAN Health Plan utilizes both Medicare and Medicaid waivers. During the first 30 months of operation, Federal and State Governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On three separate occasions, this demonstration has been extended by legislation. Current legislation (Public Law 103-66) extends the demonstration period through December 31, 1997.

92-048 Sources of Medicare Home Health Expenditure Growth: Implications for Control Options

Project No.:	17-C-90107/1
Period:	February 1992–February 1995
Funding:	$ 210,706
Award:	Cooperative Agreement
Principal Investigator:	Christine Bishop, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The overall objective of the project is to develop and consider options for restraining home health expenditure growth. The project has two phases. First is to use secondary data to examine the composition of Medicare home health expenditure growth between 1985 and 1989 and 1989 to 1991 to attribute total growth to growth in persons served, visits per person, mix of visits, and visit charges; and to attribute growth to types of agencies by auspice and scale. Second is to examine data from the Regional Home Health Intermediary data base to measure variation in types of patients served at intake, and the characteristics of high-use patients, by auspice and region, and to consider differences in mix and intensity of services provided.

Status: The first phase has been completed, resulting in an overview entitled "Recent Growth in Medicare Home Health: Sources and Implications." An edited version of this analysis, "Recent Growth of Medicare Home Health," by Christine Bishop, Ph.D., and Kathleen Carley Skwara, was published in *Health Affairs*, 12(3):95–110, Fall 1993. The second phase will be completed in February 1995.

92-026 Special Care Managed Care Initiative

Project No.:	18-C-90127/5
Period:	February 1992–July 1995
Funding:	$ 656,270
Award:	Cooperative Agreement
Principal Investigator:	Howard Garber, Ph.D.
Awardee:	Wisconsin State Department of Health and Social Services 1 West Wilson Street P.O. Box 309 Madison, WI 53701-0309
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: The purpose of the special care initiative project is to gain improved understanding of the need, utilization, and cost of delivery of health services to high-risk, severely disabled persons. The severely disabled population is a significant user of medical services. Moreover, cost between 1988 and 1991 increased at a rate double the rate of population increase. Therefore, an important objective is to contain the cost and utilization of Medicaid services of severely disabled persons while maintaining or improving the level of client satisfaction. Special Care, Inc. (SCI), is an independent, nonprofit organization that represents a joint venture between the Milwaukee Center for Independence, a Milwaukee rehabilitation facility, and the Wisconsin Health Organization, an established health maintenance organization. SCI will create specialized services, including a dedicated physician panel, case management services, and clinical services as strategies to assess medical need and to better coordinate service resources available in the community. The State of Wisconsin will

use a capitation methodology for reimbursement to SCI. Enrollment of SCI members will be voluntary. As a research and demonstration program, it aims to improve the understanding of the need, utilization, costs, and cost management opportunities associated with the delivery of health services to high-risk, severely disabled persons. These individuals are disabled, categorically needy, noninstitutionalized, exempt from the "spend-down" provisions, eligible for Medicaid, and eligible for Supplemental Security Income disability benefits. The diagnostic distribution of cases within this population is 41 percent mental retardation, 17.4 percent chronic mental illness, 13.5 percent skeletal/muscular, 11.2 percent epilepsy, 9.3 percent cerebral palsy, 1.6 percent cardiac/circulatory, 1.2 percent autism, and 4.9 percent other. This is a severely disabled and generally unemployable population whose medical care use and cost experience show a non-normalized pattern. The average hospital length of stay for this group is 7 times longer than that for the general population. Their hospital costs are 4 times higher without clear explanation. To measure the performance of the SCI program, a management information system (MIS) file will be created to match the demographic characteristics of program participants with the cost and utilization data obtained from the history files maintained by the Wisconsin Medicaid program. Medicaid data will include service and procedure frequencies, service mix, billings and reimbursements, provider practices, and certain medical status indicators. MIS files will contribute additional information on disability condition, enrollment information, benefit coordination, and case management. In addition, data on client satisfaction, quality of care, and enrollment/disenrollment decisions will be collected.

Status: Although SCI was to begin providing services during 1992, the operational phase was delayed until June 1994. Service provision began in June 1994, consistent with the 1994 timeline. Enrollment will be phased in during the first year of operations beginning with approximately 100 recipients. In April 1994, a contract for the evaluation of the SCI program was signed between the Wisconsin Department of Health and Social Services and the Human Services Research Institute. A site visit was conducted in June 1994, and a draft work plan is being developed.

92-102 State Responses to Medicaid Estate Planning
(Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/36
Period:	May 1992–May 1993
Funding:	$ 41,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The purpose of this report is to provide readers with an overview of recent State initiatives regarding Medicaid estate planning. Data for the report were collected primarily through phone interviews with key personnel at Medicaid eligibility offices in 26 States. In those States where initiatives were under way, copies of recent legislation, regulations, task force reports, internal memoranda, and other documents were obtained and reviewed. This project was completed by Brian Burwell of SysteMetrics, A MEDSTAT Division, under subcontract to Lewin/VHI, Inc.

Status: The study found that many States are attempting to place limitations on asset transfers in an effort to restrict Medicaid estate planning practices. Furthermore, States have expressed a strong desire for Federal clarification on Medicaid transfer-of-asset provisions and want additional Federal legislation which further restricts the transfer of assets. The final report will be submitted to the National Technical Information Service.

87-006 Study of Home Health Care Quality and Cost under Capitated and Fee-for-Service Payment Systems

Project No.:	17-C-99051/8
Period:	June 1987–February 1994
Funding:	$ 1,683,773
Award:	Cooperative Agreement
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard Suite 706 Denver, CO 80222
HCFA Project Officer:	Barbara Greenberg, Ph.D. Division of Long-Term Care Experimentation

Description: This project was designed to evaluate service utilization, quality, and cost of Medicare home health care provided under capitated and fee-for-service (FFS) payment systems. During the period from November 1989 through June 1991, longitudinal data were collected from a stratified random sample of 1,632 Medicare beneficiaries admitted to 38 home health agencies (HHA). Data collection occurred at admission and at 3-week,

6-week, 9-week, and 12-week intervals (or at patient discharge if it occurred prior to 12 weeks). Secondary data analysis was conducted on a sample of 10,000 Medicare beneficiaries using Medicare claims data to compare service use patterns among post-hospital Medicare patients discharged to skilled nursing facilities, home health care facilities, and the community, as well as Medicare home health patients admitted from the community.

Status: The final report was submitted in February 1994. Data indicate that FFS patients had better home health outcomes and higher costs than managed care patients had. Further, managed care patients in health maintenance organization (HMO)-owned HHAs had poorer outcomes than patients who received care from HMO-contractual agencies had. Typically, FFS patients had received more home health visits than HMO patients and within the managed care environment, HMO-owned HHA patients had received fewer visits than HMO-contractual agency patients had. The findings suggest that HMOs and particularly HMO-owned HHAs are overly restrictive in providing home health services. The findings from this study, prepared by Peter W. Shaughnessy, Ph.D, Robert E. Schlenker, Ph.D., and David F. Hittle, Ph.D., appear in the article, "Home Health Care Outcomes Under Capitated and Fee-for-Service Payment," in the *Health Care Financing Review*, 16(1):187–222, Fall 1994.

91-072 **Study of Medicare Home Health Agency Use of the Home Health "Case Management" Benefit**

Project No.:	99-C-99168/3
Period:	September 1991–July 1993
Funding:	$ 81,848
Award:	Cooperative Agreement
Principal Investigator:	Robyn Stone, Sc.D.
Awardee:	The People-to-People Health Foundation, Inc. (See page 210)
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation

Description: For this study, researchers analyzed Medicare claims and plan of treatment data for home health agencies (HHA) to examine the agencies' provision of skilled patient management. Recent information suggests that the use of this service has increased significantly in recent years as a result of changes in the interpretation of coverage requirements for home health care. Analytical files were constructed and used to conduct episode analyses and to link plan of treatment data with Medicare claims data. This study will provide the Health Care Financing Administration with information on the characteristics of patients who are receiving this service and the types of HHAs that are furnishing the service.

Status: The final report has been completed and is being submitted to the National Technical Information Service.

87-001 **Study of Post-Acute Care** (Formerly, Natural History of Post-Acute Care for Medicare Patients)

Project No.:	17-C-98891/5
Period:	December 1986–May 1994
Funding:	$ 3,702,330
Award:	Cooperative Agreement
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	The University of Minnesota School of Public Health 704 Washington Avenue, SE., Suite 203 Minneapolis, MN 55414
HCFA Project Officer:	Barbara Greenberg, Ph.D. Division of Long-Term Care Experimentation

Description: This is a study of the cost and outcomes of post-acute care (PAC). It is jointly funded by the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation. The study has two major components. The first is a RAND Corporation analysis of Medicare data to assess differences in patterns of care across the country and to determine the extent of substitution of one PAC modality for another. For this analysis, RAND utilized a 20-percent random sample of Medicare billing data for all Medicare discharges from acute hospitals during the 12 months ending in June 1985. The second is designed to address three basic questions about Medicare PAC: what are the factors associated with the receipt of different types of PAC?; adjusting for differences in case mix, are there variations in patient outcomes associated with the different sources of PAC?; and what are the costs associated with using different types of PAC? To address these research questions, the University of Minnesota collected data on 2,248 Medicare beneficiaries who were discharged in 1988–89 from 52 hospitals in 3 metropolitan areas (Minneapolis/St. Paul, Pittsburgh, and Houston). The study's sample consisted of patients who were classified with one of five diagnosis-related groups (DRG): DRG 14-stroke, DRG 88-chronic obstructive pulmonary disease, DRG 127-congestive heart failure, DRG 209-hip replacement, and DRG 210-hip fractures.

These five DRGs make up approximately one-eighth of all Medicare hospital discharges and account for a substantial percentage of PAC utilization. During the analysis, DRG data were modified to create a separate category for hip fractures treated by hip replacement. Data were collected through interviews with patients prior to discharge at 6-week, 6-month, and 12-month intervals. Data also were collected from medical record abstracts, Medicare claims data, and interviews with informal caregivers. A panel of rehabilitation experts was used to develop models for optimal discharge locations based on clinical and functional information. The models incorporated a number of outcomes: change in functional status, condition-specific outcomes, death, and rehospitalization.

Status: The final report was reviewed and accepted in May 1994. Some important findings produced from this study are: Home health care is usually the least expensive PAC choice and often is associated with good patient outcomes. Inpatient rehabilitative care is significantly more expensive than are other forms of care and fails to reduce subsequent medical costs. However, in certain cases, it produces better patient outcomes. Nursing home care generally does not produce good patient outcomes. In many cases, patients who go home without formal home health services tend to have good patient outcomes. This underlines the critical role of informal caregivers and the need to find ways to provide them with support without creating uncontrolled demands for payment for their services. Discharge planning choices often fail to maximize patient outcomes. However, it may be possible to begin developing an empirical data base that relates patient outcomes to PAC modalities by further refining the methodology used in this study. The findings, prepared by Robert L. Kane, M.D., Michael Finch, Ph.D., Qing Chen, Lynn Blewett, Ph.D., *et al.*, in the article, "Post-Hospital Home Health Care for Medicare Patients," in the *Health Care Financing Review* 16(1):131–153, Fall 1994.

91-098 Synthesis of Financing and Delivery of Long-Term Care for the Disabled Non-Elderly (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/30
Period:	June 1991–November 1994
Funding:	$ 30,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: This study synthesizes the current literature and information from various data sources on the financing and delivery of long-term care for the disabled non-elderly. This study also summarizes the current knowledge of: demographic and economic characteristics of the disabled non-elderly, types of services and patterns of service use by the disabled non-elderly, how these services for the disabled non-elderly are paid, and other unique issues related to the disabled non-elderly. This work will be completed by Joshua Wiener of The Brookings Institution under subcontract to Lewin/VHI, Inc.

Status: This project is targeted for completion in November 1994.

91-099 Synthesis of Literature on Effectiveness of Special Assistive Devices in Managing Functional Impairment (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/28
Period:	August 1991–May 1994
Funding:	$ 32,600
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D Division of Long-Term Care Experimentation

Description: This synthesis has two components. The first is a description of the special assistive devices and a summary of how these devices are paid for under the current system. The second is a summary of the effectiveness of special assistive devices in managing functional impairments. This synthesis also discusses various policy options, which relate to alternative financing arrangements for special assistive devices. The analysis of assistive device usage is obtained using the 1984 Supplement on Aging and the 1990 National Health Interview Survey Supplement on Assistive Devices. Kevin Coleman of Lewin/VHI, Inc., was the lead analyst.

Status: This paper found that the number of persons using various types of home medical equipment, both younger (under 65 years of age) and older (65 years of age or

over) persons, are sizeable and appear to be growing. While most persons using home medical equipment indicate they have access to all the devices they need, there are some significant unmet needs, particularly for persons of lower incomes who have difficulty affording this equipment. Finally, many insurers who limit their coverage of home medical equipment, either by restricting reimbursement to a limited set of devices or only reimbursing for equipment used by acute, post-acute, and/or subacute care patients, may find it cost effective to broaden coverage. In particular, the Medicare and Medicaid programs may find it cost effective to provide coverage for home medical equipment used by long-term care patients, particularly if the use of this equipment delays or avoids institutional stays. The final report will be sent to the National Technical Information Service.

91-100 **Synthesis of Literature on Targeting to Reduce Hospital Use** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/5
Period:	September 1991–October 1993
Funding:	$ 30,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D Division of Long-Term Care Experimentation

Description: This study synthesizes the literature on targeting across a variety of types of programs, all of which have the goal of reducing hospital use. These programs include geriatric evaluation units, nursing home staffing enhancement programs, and hospital-based programs for discharge planning and transitional case management. Although targeting is an issue for all of these types of programs, little attention has been given to evaluating targeting criteria. This project has been subcontracted to Jennifer Schore of Mathematica Policy Research, Inc.

Status: This review of the literature points to the all too familiar gaps in the current health care system. They include the lack of overall coordination and monitoring of care for the elderly, an insufficient level of primary and acute care for nursing home patients, poor access to a range of subacute services and a shortage of physicians with geriatric training for community-dwelling elderly persons, and insufficient efforts to prevent the highest costly diseases and to reduce complications that arise during hospitalization. The literature also suggests that several groups of elderly might benefit from such interventions as comprehensive geriatric assessment, enhanced hospital discharge planning, and the social health maintenance organization. These groups include individuals whose conditions are difficult to stabilize or who require regimens of medications or diet that must be monitored for compliance or change, individuals for whom medications are likely to lead to adverse events, and individuals facing nursing home placement without first being evaluated for rehabilitative potential. The final report will be sent to the National Technical Information Service.

91-101 **Synthesis of the Nursing Home Bed Supply** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/23
Period:	May 1991–September 1994
Funding:	$ 49,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: Analyses have shown that there is excess demand for nursing home care. Part of this excess demand is attributed to State-imposed constraints on the supply of nursing home beds. States have imposed these supply constraints in an attempt to control their Medicaid budgets and to redirect resources from institutional to noninstitutional care. This synthesis addresses:

- How much variation is there in the supply of nursing home beds?
- Why do variations in the supply of beds exist across States?
- What extent does a State's capital reimbursement system encourage/discourage sufficient investment of capital to meet its demand for new beds?
- What is the relationship between certificate of need and capital replacement?
- What is "excess demand" and how is it measured?

Barbara Manard of Lewin/VHI, Inc., was the lead analyst.

Status: This report found that much of the attention paid to the adequacy of a State's supply of nursing home beds focuses on the effect that supply has on access to care

and often ignores important demand-side issues. One of these issues, the subsidization of health care expenses for Medicaid beneficiaries, results in excess demand for nursing home services by Medicaid beneficiaries who are encouraged to demand more services than they otherwise would. This study found that, in general, access problems do not exist for private patients. However, access problems do exist for some Medicaid beneficiaries, especially for heavy-care persons with head injuries, with behavioral problems, or who need ventilators. Since each State has a unique long-term care system, measures of the adequacy of the supply of nursing home beds in one State may not accurately measure the adequacy of supply in another State. Furthermore, given the differences in programs, laws, and market conditions across States, policies that help control long-term care expenses in one State should not be adopted for use in other States. The final report will be sent to the National Technical Information Service.

91-103 Synthesis of Reimbursement Options (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/10
Period:	September 1991–December 1993
Funding:	$ 77,600
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The purpose of this synthesis is to assist the Health Care Financing Administration and other relevant policymakers in answering specific questions concerning nursing home reimbursement. The first part of the synthesis is organized into four sections: summary, overview of the Medicaid reimbursement system and State policy goals, design of the details of a reimbursement system, and analysis of options for capital reimbursement. The second part is organized into two sections:

- Synthesis of research studies relevant to modifying the current method by which skilled nursing facilities (SNF) receive payment under Part A of the Medicare program.
- Synthesis of research studies relevant to replacing the current system with a system under which Medicare SNF payment would be made on the basis of prospectively determined rates.

Barbara Manard of Lewin/VHI, Inc., was the lead analyst.

Status: This synthesis draws four major conclusions from the literature. First, there is little consensus about the best way to reimburse for nursing home capital costs. Second, empirical research on the actual impact of alternative capital reimbursement systems is extremely limited. Third, specific design features, rather than the general reimbursement system structure, ultimately determine Medicaid outlays and the rate of return to investors. Fourth, the impact of capital reimbursement on nursing home investment varies across States depending on the characteristics of the market for nursing home care. The final report will be sent to the National Technical Information Service.

91-102 Synthesis of Unmet Need for Long-Term Care Services (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/29
Period:	June 1991–December 1994
Funding:	$ 27,400
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 153)
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The purpose of this study is to conduct a literature review and prepare a synthesis of previous work in the area of unmet need for long-term care services. Included is an analysis of data from the National Long-Term Care Surveys, the 1984 Supplement on Aging, the Longitudinal Study of Aging, and the Channeling demonstration projects. This study explores possible measures that can be constructed from national data bases to assess unmet need for long-term care services. The study evaluates the merits of alternative measures, establishes definitions of unmet need to be tested in a subsequent analysis, and this develops a framework for comparing this analytic work with earlier studies. This work will be completed by Barbara Lyons of The Johns Hopkins University School of Hygiene and Public Health under subcontract to Lewin/VHI, Inc.

Status: A draft report will be submitted in October 1994.

91-056 Testing the Predictive Validity of Using Medicare Claims Data to Target High-Cost Patients

Project No.:	99-C-98526/1
Period:	August 1991–July 1993
Funding:	$ 139,898
Award:	Cooperative Agreement
Principal Investigator:	Christine Bishop, Ph.D.
Awardee:	Brandeis University
	(see page 84-002)
HCFA Project Officer:	Phyllis A. Nagy Division of Long-Term Care Experimentation

Description: For this study, Brandeis will investigate the feasibility of using historical Medicare claims data of patients hospitalized with certain primary diagnoses to identify a subset of patients who are more likely to incur high levels of Medicare reimbursements in the future. Analysis will be restricted to a sample of hospital patients with selected illnesses where past research indicates the specific patient diagnosis eventually results in higher Medicare costs, and it is determined that targeted case management or coordinated care programs can be potentially effective (based on research and/or professional clinical judgment) in reducing overall health care costs.

Status: A preliminary study design has been completed. However, the development of an analytic research file has been delayed. The final report is expected in late 1994.

92-028 Texas Medicare Nursing Home Case-Mix and Quality Demonstration

Project No.:	95-C-90019/6
Period:	February 1992–June 1996
Funding:	$ 307,382
Award:	Cooperative Agreement
Principal Investigator:	Stephen Lorenzen, Ph.D.
Awardee:	Texas Department of Human Services P.O. Box 149030 (MC-E-601) Austin, TX 78714-9030
HCFA Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: Texas will participate in The Multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration. The objective of the demonstration is to test the feasibility and cost effectiveness of a case-mix payment system for nursing facility services under the Medicare and Medicaid programs that are based on a common patient classification system. The addition of Texas enhances the Health Care Financing Administration's ability to project the results of the demonstration on a national basis. Texas represents a western pattern of service using more proprietary multistate chain providers than is the pattern used in the East. Twenty Texas Medicare facilities were part of the original data collection for the development of the resource utilization group (RUG) III system. Texas has the second largest number of hospital-based facilities in the country. There are more than 20 metropolitan statistical areas of varying size. In addition, the State has a large number of rural areas. The State was traditionally a flat-rate intermediate care facility Medicaid system until 1989 when it implemented a RUG-type Medicaid payment system. This RUG-type payment system makes Texas well-suited for inclusion in the Medicare portion of the demonstration.

Status: During the first year of participation, the Texas Department of Human Services worked with the Texas Department of Health to change the resident assessment instrument being used in the State. In April 1993, Texas implemented the minimum data set plus statewide as its resident assessment instrument. Analyses of 1990 Medicare Cost Report data, Medicare provider analysis and review Part A skilled nursing facility stay data, and the Texas Client Assessment and Review Evaluation (CARE) data have been conducted for use in developing the demonstration's Medicare case-mix payment system. Under the Medicaid demonstration, Texas began development of the Quality Evaluation System of Texas, a resident characteristic information and reporting system using the CARE instrument. During the first year, the staff continued the development and enhancement of the system, which was codified into law by the Texas Legislature in summer 1993. They now are producing facility-level reports with statewide comparisons for Texas providers on a twice-a-year basis. The Medicare portion of the NHCMQ demonstration is expected to become operational in early 1995.

87-009 Texas Nursing Home Case-Mix Demonstration

Project No.:	11-C-99131/6
Period:	September 1987–April 1994
Funding:	$ 532,830
Award:	Cooperative Agreement
Principal Investigator:	Ken C. Stedman

Awardee:	Texas Department of Human Services P.O. Box 149030 (MC-E-601) Austin, TX 78714-9030
HCFA Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: This Texas Department of Human Services' project has two parts. First was to develop, implement, and evaluate a Medicaid prospective case-mix payment system. The payment system is based on feasibility studies sponsored by the Health Care Financing Administration. The major Medicaid objectives of this part are: match payment rates to resident need, promote the admission of heavy-care patients to nursing homes, provide incentives to improve quality of care, improve management practices, and demonstrate the administrative feasibility of the new system. Second is to develop and pilot test a case-mix-adjusted prospective payment system (PPS) for Medicare patients in skilled nursing facilities. The objective of the Medicare pilot test is to develop and implement the administrative processes for a Medicare PPS in three facilities, based on a resource utilization group (RUG) classification. The index that will be used for the classification of Medicare patients is the RUG-T18, which uses the same clinical groups and the activities of daily living (ADL) scale used in the New York RUG's II system. The difference occurs in the expanded rehabilitation groups for Medicare patients. Texas will use a quasi-experimental design for the Medicare pilot test to compare the effect of introducing case-mix payment in a small group of experimental facilities in one catchment area versus continuing the flat-rate, cost-based system in a control catchment area. The State is using a pre/post-design for the Medicaid system. Case-mix classifications are based on a review of six different systems in which the New York RUG's II explained the greatest variance of staff time. Case-mix indexes borrow major elements of the RUG's II system and some of the rationale from the Minnesota system. The Texas index of level of effort (TILE) uses four clinical groups to form clusters and to develop subgroups using an ADL scale. A quality of care information and reporting system called The Quality Evaluation System of Texas was developed and tested. Two third-party evaluations are under way: one on data reliability and one on the validity of the data analysis methods.

Status: During the first year, the TILE and RUG-T18 indexes were reviewed for compatibility. The Medicaid payment system became operational statewide under the Texas Medicaid State plan in April 1989. As of the end of the Medicaid part in fall 1992, over 102,000 Medicaid recipients had been a part of the demonstration. An evaluation data base consisting of the Medicaid Client Assessment, Review, and Evaluation claims documents for the 102,000 recipients with at least 3 assessments is being used for the evaluation. Medicare waivers were approved, and the Medicare pilot test was implemented in three Austin area nursing homes in November 1992 for a period of 18 months. At the time of their 1991 Federal certification survey, the pilot-tested facilities had 59 Medicare Part A-covered residents. Cost analyses of both national and State samples of Medicare providers were performed to arrive at baseline costs for calculating the rates for the RUG-T18 groups. The modified patient assessment instrument, the minimum data set plus, that was developed for the Multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration is being used for Medicare classification. In the Medicare pilot, a nurse has reviewed weekly new admissions onsite to verify the classification of the residents into the RUG-T18 groups and to give prior authorization of the Medicare stays for specific time intervals. The interrater reliability between the project nurse and the facility nurses has been excellent. A paper, "Texas Medicare Case-Mix Pilot Study," which describes the pilot test and the data reliability processes, has been prepared. The lessons learned from this pilot will be used in implementating the NHCMQ demonstration.

94-084 Use of Long-Term Care Services by Mentally Ill Persons

Project No.:	17-C-90341/3
Period:	September 1994–September 1996
Funding:	$ 391,331
Award:	Cooperative Agreement
Principal Investigator:	Dennis Shea, Ph.D.
Awardee:	Center for Health Policy Research Institute for Policy Research and Evaluation Pennsylvania State University Office of Sponsored Programs 110 Technology Center University Park, PA 16802
HCFA Project Officer:	Ellen O'Brien Division of Long-Term Care Experimentation

Description: Recent regulatory policies addressing mental health care in nursing homes and current debate on the role of long-term care (LTC) and mental health care in health care reform have ignored the connections between the two. The significant physical and mental comorbidity among younger and older mentally ill persons, however, links the two. To understand the impact of policy and regulations on nursing homes, nursing home residents,

and mentally ill persons, the LTC service use by mentally ill persons will be examined. The first project objective is to describe the patterns of nursing facility use by persons with a mental illness, (including admission and discharge), use of services while in nursing facilities, as well as lengths of stay, and expenditures. The second objective is to analyze individual, facility, and systemic determinants of the use of nursing facilities and other services—especially psychiatric and psychological services—by persons with mental illness. The ultimate goal of this research is to provide a complete description and analysis of the LTC service use patterns of persons with mental illness, adding to our understanding of the likely impact of current policy and future policy changes on the service use of this special population.

Status: This project is in the early developmental stage.

88-014 Use of Medicaid Reimbursement Data in the Nursing Home Quality Assurance Process

Project No.:	18-C-99256/5
Period:	June 1988–August 1993
Funding:	$ 925,389
Award:	Cooperative Agreement
Principal Investigator:	David R. Zimmerman, Ph.D.
Awardee:	Center for Health Systems Research and Analysis University of Wisconsin–Madison Room 1163, WARF Office Building 610 Walnut Street Madison, WI 53705
HCFA Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: The purposes of this project are to assess the feasibility of using Medicaid reimbursement data to target facilities and residents in the nursing home quality assurance survey process and to develop a set of quality of care indicators (QCI) using resident assessment data. Medicaid reimbursement data on medication use, sentinel health event, and other indicators are being provided to surveyors in preparation for the field survey to help target facilities for more intensive review, to identify specific areas of deficient care, and to identify individual residents for more detailed review. The objectives of the project are to:

- Convert reimbursement data into specific QCIs.
- Identify the Federal regulations for which the use of QCIs has the greatest potential benefit.
- Develop and demonstrate in one State (Wisconsin) procedures for providing QCIs to survey staffs.
- Assess the potential for implementing the system in other States.
- Develop a set of quality indicators (QI) using resident assessment information, sometimes in combination with claims data, that can be used in the survey process as part of The Multistate Nursing Home Case-Mix and Quality Demonstration.

Status: A program was implemented on December 1, 1990, in which a randomly assigned group of survey teams in two Wisconsin regions were provided information on 33 QCIs for each nursing facility prior to the survey. Surveyors used the QCI information in selecting residents for indepth review and in determining whether care deficiencies should be cited. The surveyors completed and returned a feedback report that documented the results of QCI residents' investigations. Through November 1991, QCIs were used in approximately 120 surveys, in addition to the 17 surveys in which they were used in a pilot study. The quality monitoring information system has been pilot-tested, and quality indicators for 12 quality of care domains have been revised. Wisconsin produced a training manual for the four States in the pilot test, as well as an overview of the proposed QIs and the process for using these QIs in the Federal nursing home survey process. These are available for distribution. The final report covering the QCIs which use Medicaid claims data and the QIs which use minimum data set information has been submitted.

92-040 Validation of Nursing Home Quality Indicators

Project No.:	18-C-90090/9
Period:	July 1992–July 1995
Funding:	$ 788,808
Award:	Cooperative Agreement
Principal Investigator:	Tamra J. Lair, Ph.D.
Awardee:	SysteMetrics/McGraw-Hill 104 West Anapamu Street Santa Barbara, CA 93101
HCFA Project Officer:	Kay Lewandowski Division of Long-Term Care Experimentation

Description: This project is a continuation of a cooperative agreement to investigate the usefulness of claims data from Medicaid and Medicare administration record systems as sources of nursing home quality of care measures. The previous study involved retrospective analysis of 1987 Medicaid and Medicare claims data and facility deficiency data from two States. The goal of this project is to further the development of an automated quality assurance system using Medicare and Medicaid

claims data to provide continuous monitoring of the quality of care rendered to Medicaid recipients in long-term care facilities. The objective is to validate the resident-level claims-based quality of care indicators (QCI) by recomputation of the claims-based indicators for two States using data for 1990; physician and nurse examination of medical records for a sample of residents in a sample of nursing homes for these two States; and establishment of the relationship of the QCIs to cited deficiencies and adverse outcomes.

Status: This project has developed preliminary QCIs and is refining these indicators for continuing analysis.

Consumer Information

IM-031 Breast Cancer Treatment Initiative

Funding:	Intramural
HCFA Project Director:	Joan L. Warren, Ph.D. Division of Beneficiary Studies

Description: As part of a new consumer information strategy (CIS), the Health Care Financing Administration (HCFA) is seeking to use its administrative claims data to help its beneficiaries make more informed choices about available cancer therapies. Breast cancer will be one of the first topics addressed by the initiative. CIS involves outreach and awareness programs for beneficiaries as well as for health care professionals. One important aspect of outreach is the development and dissemination of utilization information derived from the National Claims History file. HCFA wishes to include findings from Medicare data to educate elderly female beneficiaries about the full range of therapeutic options open to them if they should develop breast cancer. These data also will be provided to health care professionals. The Office of Research and Demonstrations is working with the Health Standards and Quality Bureau and Fu Associates in exploring how completely HCFA's administrative claims capture patterns of breast cancer treatment. Once the completeness of the data is understood, rates of procedures and service utilization (i.e., radiation therapy following lumpectomy) will be developed by age and race for different geographic areas. Information may be disseminated via regional offices, peer review organizations, consumer organizations, and medical societies and associations.

Status: The exploration of data completeness is proceeding and educational information is being compiled. A meeting of national opinion leaders to discuss data dissemination is pending for October 1994. The final form and timing of data release will be determined.

94-099 Effects of Information and Consumer Knowledge on Choice of Health Plans

Project No.:	17-C-90348/5
Period:	September 1994–March 1996
Funding:	$ 193,096
Award:	Cooperative Agreement
Principal Investigator:	Francois Sainfort, Ph.D.
Awardee:	Center for Health Systems Research and Analysis University of Wisconsin 750 University Avenue Madison, WI 53706
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Long-Term Care Experimentation

Description: The primary purpose of this research involves studying how consumers make decisions about health care coverage and what role their knowledge about health plans plays in this decision process. A computerized data collection system will be used to elicit consumer preference structures and to track the information search process, as well as record their actual plan choices under scenarios with differing amounts and types of information presented about each plan option. A pilot study based on a series of indepth, face-to-face interviews with a small group of consumers will be conducted to test and refine the initial conceptual model and to design the data collection system. A sample of 100 persons will be chosen from the study population of the employees of the State of Wisconsin living within 1 hour's driving time of Madison, Wisconsin.

Status: The project is in its design phase.

IM-030 Influenza Immunization Initiative

Funding:	Intramural
HCFA Project Director:	Daniel J. Babish Division of Beneficiary Studies

Description: As part of a new consumer information strategy, the Health Care Financing Administration is seeking to increase the number of influenza immunizations among Medicare beneficiaries to reach the Department of Health and Human Services' Year 2000 goal of a 60-percent influenza immunization rate for all elderly Medicare beneficiaries. The influenza initiative involves a public awareness campaign, outreach activities among several peer review organizations, and the production and dissemination of Medicare influenza immunization rates. Influenza immunization rates are

being developed from all claims paid by the Medicare program for Part B non-health maintenance organization enrollees 65 years of age or older who were immunized between September 1 and December 31, 1993. Rates are being prepared for the Nation and for States by county, gender, age, and race. A compilation of State maps with county-specific rates and county rates by race is being produced for distribution to State and local entities and interested groups. It is hoped that the dissemination of the data on Medicare paid immunizations will help increase awareness of the Medicare influenza immunization benefit and will assist in achieving a 60-percent immunization rate for the elderly Medicare population.

Status: The production of national maps and rates of paid influenza immunizations by race has been completed. Production of a "County Data Book" containing county-specific State maps with overall influenza immunization rates reflecting paid claims as well as county-specific rates by race is under way.

94-098 Information Needs for Consumer Choice

Project No.:	500-94-0047
Period:	September 1994–July 1996
Funding:	$ 714,719
Award:	Contract
Principal Investigator:	Barri Barrus, Ph.D.
Awardee:	Research Triangle Institute P.O. Box 12194 Research Triangle Park, NC 27709-2194
HCFA Project Officer:	Judith A. Sangl, Sc.D Division of Long-Term Care Experimentation

Description: This contract will examine the types of information consumers would find most useful in selecting health insurance plans, providers, and practitioners; and in making the chosen health care plan/system work best for them. The study will determine how to present this type of information in a user-friendly way and will develop and test these consumer information approaches in given markets. The awardee shall address consumer information issues and needs in both the current health care system and in proposals for health care system reform, especially as they relate to three broad consumer groups: Medicare beneficiaries; Medicaid beneficiaries; and the remaining U.S. population under 65 years of age. Contract tasks include conducting 24 focus groups, conducting 9 case studies of innovative consumer information projects, and developing and testing information materials in 2 different media for 6 subgroups of the Medicare and Medicaid populations.

Status: The project is in the design phase.

IM-032 Mammography Utilization Initiative

Funding:	Intramural
HCFA Project Director:	Anne A. Trontell, M.D. Division of Beneficiary Studies

Description: As part of a new consumer information strategy (CIS), the Health Care Financing Administration (HCFA) is seeking to increase the use of preventive services covered under Part B. Mammography is one of two preventive services receiving early attention under this initiative; influenza immunization is the other. CIS involves outreach and awareness programs for beneficiaries, providers, and State and local health departments. One important aspect of outreach is the development and dissemination of utilization information derived from the National Claims History file. HCFA wants to promote mammography utilization among female beneficiaries to move towards the goal for this service established by the Department of Health and Human Services (DHHS). DHHS' Year 2000 objective is for at least 60 percent of all women over 50 years of age to receive a clinical breast examination and a mammogram within the preceding 1 to 2 years. The Office of Research and Demonstrations is working with the Bureau of Data Management and Strategy (BDMS) in developing annual and biennial mammography utilization rates for all claims paid by the Medicare program for Part B non-health maintenance organization enrollees who were enrolled continuously for either 1 year or 2 consecutive years. Screening and diagnostic mammograms will be included. Age- and race-specific rates will be developed for individual years (1991, 1992, 1993) and 2-year intervals (1991–92 and 1992–93) to facilitate comparison with estimates from surveys performed by Public Health Service (PHS) agencies. Information may be disseminated in a similar fashion as that performed for influenza.

Status: BDMS is producing the data. Relationships are being established with PHS and other partners, and educational information is being compiled. State and county rates will be made available in May 1995.

90-015 Medicare Beneficiary Health Status Registry

Project No.:	500-90-0053
Period:	April 1990–December 1994 September 1990–September 1992 (Design Phase) September 1992–December 1994 (Field Test Phase)
Funding:	$ 1.8 million $ 396,940 (Design Phase) $ 1.4 million (Field Test Phase)
Award:	Contract
Principal Investigator:	Charles Turner, Ph.D.
Awardee:	Research Triangle Institute P.O. Box 12194 Research Triangle Park, NC 27709-2194
HCFA Project Officer:	Thomas W. Reilly, Ph.D. Division of Beneficiary Studies

Description: The Medicare Beneficiary Health Status Registry is a longitudinal data base that will combine survey data on the elderly with Medicare's administrative data files. As currently envisioned, the survey data will be collected through a mailed self-administered questionnaire to 2.5 percent (40,000) of the elderly as they enter the Medicare program and at decreasing intervals thereafter. Followup of nonrespondents will be via telephone interviews. Data will be gathered on risk factors, functional status, sociodemographic variables, medical history, and quality of life. This contract is for refining the development of the survey instrument and testing of survey operations. The primary goal of the registry is to measure the relationship of Medicare-reimbursed services to the health status of Medicare beneficiaries while controlling for risk factors and additional sociodemographic factors such as insurance coverage, education level, and income. Health status will be defined through measures of quality of life, perceived health, current and past medical conditions and procedures, presence of risk factors for disease, functional status, and sociodemographics. Subsequent goals are to:

- Describe, analyze, and understand health and disease longitudinally from the time of enrollment to death in successive cohorts of Medicare beneficiaries. This includes measuring the progression of illness and decline in health of beneficiaries over time and the study of the healthy elderly to understand the aging process.
- Assess and evaluate the effectiveness and impact of specific medical and surgical interventions on the health, perceived health, quality of life, well-being, and functional status of Medicare beneficiaries.
- Monitor access to care for special populations, including the ability to assess quantitative and qualitative differences in access to care. Qualitative access means that although individuals may have access, there may be differences in the quality of care such as access to new technologies. Outcomes will be assessed while controlling for differences in severity of illness.
- Describe, analyze, and understand the use and costs of health care services as they relate to Medicare, and the long-term utilization patterns and lifetime Medicare costs of individuals in successive cohorts over time as they relate to health and functional status at the person level.
- Provide a detailed sampling frame that may be used to select a highly efficient sample for studies of special subgroups in the registry sample, such as specific disease conditions and racial or ethnic groups. This sampling frame will be cost effective because a module (a set of questions directed at a specific topic) would focus specifically on questions related to the subject of interest, but have longitudinal and other data previously gathered to use in the analysis.
- Provide information to monitor the existing Department of Health and Human Services' "Healthy People 2000" objectives for the elderly and to develop additional objectives targeting the elderly population.
- Develop equitable payment adjustments for health maintenance organizations, preferred provider organizations, and other providers in rural areas.

Status: This project has completed data collection for the field test. The field test is designed to test the feasibility of using a mailed self-administered questionnaire with telephone followups on nonrespondents to collect health status data from elderly persons. Analysis of field test data will be completed in early fiscal year 1995.

IM-033 Prostate Disease Information Initiative

Funding:	Intramural
HCFA Project Director:	Maria A. Friedman Office of Operations Support

Description: As part of a new consumer information strategy, the Health Care Financing Administration is seeking to help beneficiaries make more informed choices about treatment options for prostate disease. This includes educating beneficiaries and providers about the full range of therapeutic options available for treatment of prostate-related problems. These are common in elderly men and their treatment costs Medicare millions of dollars annually. Some prostate conditions are cancerous. In fact, prostate cancer is the most common form of

cancer among American men. Surgical treatment for prostate cancer is on the rise. Yet, this course is controversial and its effectiveness has been questioned in relation to nonsurgical options. Other prostate conditions are benign. Half of all men 60 years of age or over have swelling of the prostate called benign prostatic hyperplasia (BPH). By 80 years of age, one man in four will require treatment for it. However, BPH and some of its treatments have major side effects that significantly affect beneficiaries' quality of life. For example, men with BPH often experience frequent urination or, conversely, difficulty in postponing urination. Surgical treatment of BPH can cause urinary incontinence and impotence. As a result, patients need to have information available to make an informed treatment choice. Providers need to be educated about treatment options and trained to work with consumers to help them better understand available options.

Status: Preliminary work is under way to review the statistical information available from the Medicare program, other Federal agencies, and private-sector sources and to review consumer-related information also available from the Medicare program, other Federal agencies, and private-sector sources. Use and testing of educational strategies, such as shared decisionmaking, are being explored.

Program Statistics

IM-001 **Annual Supplement: *Health Care Financing Review***

Funding:	Intramural
HCFA Project Director:	Charles R. Helbing Division of Program Studies

Description: The Annual Supplement of the *Health Care Financing Review* presents comprehensive data on the experiences of the Medicare and Medicaid programs. Each issue will contain:

- Extensive graphic presentations of longitudinal and cross-sectional data describing the demographic characteristics of program beneficiaries, patterns of service utilization, and program expenditures for the Medicare and Medicaid programs.
- Description of the eligibility criteria, benefit structures, and payment methods of the Medicare and Medicaid programs.
- Detailed longitudinal and cross-sectional tables describing the number and characteristics of Medicare and Medicaid beneficiaries, the use of Medicare and Medicaid benefits, and the amounts and distributions of program payments by State, beneficiary characteristics, and service type.

Status: The 1993–94 Supplement is in press and the publication is expected in winter 1994. This issue will contain Medicaid data for fiscal year 1992 and Medicare data for calendar year 1992. The Supplement may be obtained by subscribing to the *Health Care Financing Review*. Each subscription costs $19.00 per year, domestic; $23.75, foreign. Single issues of the Supplement cost $11.00, domestic; $13.75, foreign. Single copies and subscriptions may be obtained from the Superintendent of Documents, Post Office Box 371954, Pittsburgh, Pennsylvania 15250-7954.

IM-021 **Data Base Development**

Funding:	Intramural (See page 277)
HCFA Project Director:	Wilson G. Kirby Division of Program Studies

Description: The daily operations of the Medicare and Medicaid programs involve the processing, adjudication, and payment of claims for health care services. As a result, extensive records are maintained on program participants, services, and payments. By linking, tabulating, sampling, and summarizing records from the administrative data bases, extensive statistical files are produced. Data development entails the further development, aggregation, and linkage of these data to support research activities. This includes the development of these types of data bases:

- Benefit-specific, person-based.
- Beneficiary cost-sharing.
- Procedure-specific.
- Morbidity-specific.
- Benefit-specific data base linked with provider data bases.
- Enrollment data base linked with person-summary data bases.
- Provider of services.
- SAS and FOCUS research data bases.

The availability of person-specific and procedure-specific data make these data bases useful for epidemiological research initiatives and a myriad of other special studies.

Status: This is an ongoing, intramural research project. Most of the data bases described are maintained on a

calendar year basis. Data bases containing calendar year 1993 data are available and those containing calendar year 1994 data should be available by summer 1995.

IM-022 Data Support Activities

Funding:	Intramural
	(See page 277)
HCFA Project Director:	Charles R. Helbing Division of Program Studies

Description: This Data Support Activities project provides data processing, graphics, desk-top publishing, and statistical support services to assist analysts and researchers in developing and disseminating a wide variety of Office of Research and Demonstrations projects, congressional mandates, health care policies and legislative initiatives, and data dissemination activities. Some activities this project is involved in are Reports to Congress, *Health Care Financing Review* articles, presentations and seminars, special studies, internal reports, and press releases.

Status: This intramural project produces and disseminates current and relevant Medicare and Medicaid data on an ongoing basis. The output is maintained on computer mass storage and data diskettes. The statistical data and related information are available upon request.

90-018 Financing of Acquired Immunodeficiency Syndrome and Acquired Immunodeficiency Syndrome-Related Complex Treatment Costs by Medicaid and Medicare

Project No.:	18-C-99522/3
Period:	May 1990–March 1995
Funding:	$ 648,985
Award:	Cooperative Agreement
Principal Investigator:	Julia Hidalgo
Awardee:	Maryland Department of Health and Mental Hygiene Center for AIDS Services, Planning, and Development 201 West Preston Street Baltimore, MD 21201
HCFA Project Officer:	Penelope L. Pine Division of Program Studies

Description: The State of Maryland is developing a longitudinal data base focusing on human immunodeficiency virus (HIV)-infected people from 1981 through 1991. The project is expected to provide related illness information on the extent to which patient, provider, and payer characteristics influence cost and use of health services on expenditures in Maryland under the Medicaid and Medicare programs. Four major aspects to the study are to maintain the data systems of the Maryland Human Immunodeficiency Virus Information System as required to measure program use and financing; to compare and refine three different disease-staging approaches for predicting resource consumption and treatment outcomes during the course of the HIV disease; to retrospectively assess health services utilized by pediatric, adolescent, and adult patients with HIV; and to use annual utilization, reimbursement, and financing data to measure trends.

Status: The fourth year of the project has been completed. Calendar year 1991 Medicaid data have been obtained and data analysis has begun. The three disease-staging approaches and classification models under study are the Severity Index for Adults with AIDS (SIAA), the Severity Classification for AIDS Hospitalizations (SCAH), and the Centers for Disease Control (CDC) Disease Classification System. SCAH has been applied to a longitudinal data set of adults with aquired immunodeficiency syndrome (AIDS) hospitalizations for 1983 and 1989 to predict long-term survival. Currently, SIAA and the CDC classification are being assessed and compared to SCAH to predict survival and health services utilization. Development of the Medicare data is in early stages. These papers have been presented at various professional meetings:

- Hildalgo, J.: "Medicaid, Does Enrollment Ensure Access to Care for Persons with AIDS." AIDS Health Services Research Conference, December 1991.
- Hildalgo, J.: "Trends in the Public Financing of AIDS 1985–1990." AIDS Health Services Research Conference, December 1991.
- Hildalgo, J., Boreta, J.C., Beardsley, R., Chaisson, R., Moore, R.: "Epidemiological Monitoring of AIDS Patients: The Maryland Experience." George Washington University meeting on Drug Development in the 1990's: The Legacy of AIDS.

Publications available include:

- Hildalgo, J.: Development and Application of Statewide Acquired Immunodeficiency Syndrome Information Systems in Health Services Planning and Evaluation. *Evaluation and Program Planning*, 13:39–46, 1990.

- Hildalgo, J.: Development of a Model Longitudinal Database to Measure Outcomes and Quality of Care Among Persons with AIDS. *Quality Review Bulletin*, pp. 355–363, October 1990.
- Moore, R.D., Hildalgo, J., Sugland, B.W, Chaisson, R.: Zidovudine and the Natural History of Acquired Immunodeficiency Syndrome. *The New England Journal of Medicine*, 324(20):1412–1416, May 16, 1991.

90-062 Medicaid Analysis Project for States

Project No.:	500-90-0045
Period:	September 1990–September 1995
Funding:	$ 5,529,431
Award:	Contract
Principal Investigator:	Suzanne Dodds
Awardee:	SysteMetrics, Inc. Santa Barbara Corporate Center 5425 Hollister Avenue, Suite 140 Santa Barbara, CA 93111
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Program Studies

Description: This contract expands the collection of person-level data from the Medicaid Management Information Systems (MMIS) maintained by the States. Data are being collected from the States that have participated in the Medicaid Tape-to-Tape project. Major activities are:

- Assist in the production and verification of State Medicaid Research Files (SMRF) from Medicaid Statistical Information System Files.
- Provide a consistent complementary link between the Medicaid Tape-to-Tape project activities and the development of SMRFs.
- Obtain person-level data on Medicaid enrollment, use, payments, and providers from the State MMIS.
- Develop uniform data file structures to facilitate the comparison of Medicaid program statistics among these States.
- Produce streamlined research data bases to support analysis of policy and program management alternatives for Medicaid.

Status: The awardee is working with the Health Care Financing Administration in a major effort to construct SMRFs for eligibility and claims files.

91-036 Medicaid Data Needs

Project No.:	99-C-98489/9
Period:	August 1991–December 1993
Funding:	$ 93,690
Award:	Cooperative Agreement
Principal Investigator:	Stephen H. Long, Ph.D.
Awardee:	The RAND Corporation (See page 211)
HCFA Project Officer:	Penelope L. Pine Division of Program Studies

Description: To assist the Health Care Financing Administration (HCFA) in its efforts to evaluate current Medicaid data systems, RAND will develop a list of important Medicaid policy issues and define several research studies to address these issues, inventory the data needed to conduct these research projects, review data systems and identify gaps, and propose ways that these gaps may be filled. By enumerating the data needs of a variety of different types of projects and evaluating data systems in light of those needs, RAND will identify data activities necessary to support Medicaid health services research.

Status: RAND has identified the policy issues and the relevant research topics. These research topics provide a framework for the evaluation of current data. The specific topics include Medicaid participants access to acute care; factors affecting increases in Medicaid expenditures; managed care utilization; eligibility expansions; long-term care reimbursement; Medicaid expansions for women and children; drug formularies; and followup of early and periodic screening, diagnosis, and treatment. The final report is available from the HCFA project officer.

92-056 Medicaid Program Research to Study Medicaid Policy Alternatives for the State of New York

Project No.:	500-92-0059
Period:	September 1992–March 1995
Funding:	$ 194,090
Award:	Contract
Principal Investigator:	Thomas Fanning, Ph.D.
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, NY 12243-0001
HCFA Project Officer:	Gloria Smiddy Division of Program Studies

Description: The purposes of this contract are to provide the Health Care Financing Administration (HCFA) with greater capability to conduct Medicaid program research

and to study Medicaid policy alternatives for the State of New York. Primary goals to:

- Obtain person-level Medicaid Management Information Systems data from the State.
- Produce research data sets for analysis of Medicaid costs and service utilization.
- Conduct policy-oriented research studies derived from knowledge of the data, program characteristics, and policy issues that exist in the New York Department of Social Services.
- Provide support to HCFA staff who will conduct policy-related studies using New York Medicaid research data sets.

Status: New York Medicaid enrollment and claims files for Federal fiscal years 1990, 1991, and 1992 have been received. The studies using the New York data are Physician Participation in the Medicaid Program, Preferred Physician and Children Program, and Substance Abusing Pregnant Women. A presentation on Physician Participation in Medicaid: Implications for Vulnerable Populations was given by Cynthia Tudor at the 8th annual meeting of the Association of Health Services Research in June 1994.

93-064 Medicare Beneficiaries Receiving Chronic Renal Dialysis Not Identified as Having End Stage Renal Disease

Project No.:	HCFA-93-0979
Period:	August 1993–May 1994
Funding:	$ 24,813
Award:	Contract
Principal Investigator:	Dennis Cotter
Awardee:	The Medical Technology and Practice Patterns Institute 2121 Wisconsin Avenue, Suite 230 Washington, DC 20007
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Beneficiary Studies
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The Medical Technology and Practice Patterns Institute (MTPPI) has identified some Medicare beneficiaries who are submitting bills indicating they are receiving chronic renal dialysis, but who are not identified as having end stage renal disease (ESRD) or included in the ESRD Program Management and Medical Information System (PMMIS) data base. MTPPI will design algorithms to identify ESRD patients from Medicare dialysis bills based on accepted clinical practice. MTPPI will estimate the impact of these persons on ESRD program enrollment, incidence, demographic characteristics, and costs.

Status: MTPPI has identified persons receiving chronic renal dialysis who are not included in the PMMIS and has submitted a request for the data necessary to estimate patient counts and costs.

94-005 Patterns of Utilization and Expenditures for Prescription Drugs in Selected State Medicaid Programs

Project No.:	500-92-0020DO08
Period:	January 1994–July 1995
Funding:	$ 236,705
Award:	Delivery Order in Master Contract
Principal Investigator:	Rezaul Khandker, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) (See page 212)
HCFA Project Officer:	Herbert A. Silverman, Ph.D. Division of Program Studies

Description: This project will analyze Medicaid data from selected States to describe patterns of prescription drug use and expenditures. The focus will be on the differential use of specific classes of drugs by classes of beneficiaries defined by demographic characteristics and program eligibility status. The impact of State administrative limits on prescription size and frequency of refills will be examined. At this time, the eight States included in the study are Alabama, California, Delaware, Georgia, Kentucky, Missouri, New Jersey, and Wyoming.

Status: This project is in the early implementation stage.

IM-020 Program Information Inquiries

Funding:	Intramural (See page 277)
HCFA Project Director:	Roger E. Keene Division of Program Studies

Description: The primary objective of the Program Information Inquiries project is to provide the Health Care Financing Administration (HCFA), other Federal Government agencies, and the entire health care community with current and historical Medicare and Medicaid data in response to health care information requests. Medicare and Medicaid data and related information are available on enrollment, service

utilization, program payments, providers of services, morbidity, procedures, diagnosis-related groups, and beneficiary cost-sharing.

Status: This ongoing intramural project derives data from an extensive inventory of HCFA statistical and analytical files, which are a by-product of the daily administrative operations of the Medicare and Medicaid programs involving the processing, adjudication, and payment of claims for covered health care services. Program-wide data generally are available within 9 months after the close of the year and are available upon request.

Master Contracts and Research Centers

84-002 Brandeis University Health Policy Research Consortium

Project No.:	99-C-98526/1
Period:	March 1984–July 1993
Funding:	$ 12,943,396 (Total funds awarded for projects from March 1984 through July 1993)
Award:	Cooperative Agreement
Principal Investigator:	Jerry F. Boren, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street Waltham, MA 02254-9110
HCFA Project Coordinator:	Michael J. Baier Office of Operations Support

Description: The Brandeis University Health Policy Research Consortium (HPRC) included the Boston University School of Medicine; the Center for Health Economics Research, Needham, Massachusetts; and The Urban Institute Health Policy Center, Washington, D.C. These institutions provided expertise in the areas of health services delivery issues, physician payment alternatives, and long-term care policy options, as well as microsimulation and data processing capabilities.

Status: Each year, the Brandeis HPRC and the Health Care Financing Administration jointly developed an agenda of specific topics and projects. The Center completed its eighth and final year on July 30, 1993. This edition of the *Status Report* describes the status of some projects conducted during that final year. The project titles, for which full descriptions are contained in the appropriate sections, are:

Health Care Systems Reform and Financing

- Indexes for Adjusting Medicaid Eligibility and Matching Rates.

Provider Payment

- Methods for Tracking Volume/Intensity Change.

Access and Quality of Care

- Extending Medicaid Coverage of Substance Abuse Treatment to Eligible Pregnant Women: Assessment of Issues and Costs.
- Implementing Findings on Volume and Quality.
- Trends in Access to Physician Services.

Subacute and Long-Term Care

- Determinants of Home Care Costs.
- Interaction of Medicaid and Private Long-Term Care Insurance.
- Testing the Predictive Validity of Using Medicare Claims Data to Target High-Cost Patients.

92-083 Medicaid Demonstration and Evaluation Support Projects: Master Contract: Abt Associates Inc. (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0034
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	David Kidder
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly

reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount of the first DO, 500-92-0034DO01, Management Delivery Order is $32,845.

This awardee has not been awarded any additional delivery orders.

92-085 **Medicaid Demonstration and Evaluation Support Projects: Master Contract: Lewin/VHI, Inc.** (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0036
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Allen Dobson, Ph.D.
Awardee:	Lewin/VHI, Inc. 9300 Lee Highway, Suite 400 Fairfax, VA 22031-1207
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount of the first DO, 500-92-0036DO01, Management Delivery Order, is $26,797.

This awardee has not been awarded any additional awards.

92-086 **Medicaid Demonstration and Evaluation Support Projects: Master Contract: Mathematica Policy Research, Inc.** (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0037
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	George E. Wright, Ph.D.
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW., Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount of the first DO, 500-92-0037DO01, Management Delivery Order is $27,569.

The individual DO projects awarded under this master contract are described in detail in the following sections of this *Status Report*.

Access and Quality of Care

- Feasibility Study to Develop a Multistate Medicaid Reciprocity Program for Migrant and Seasonal Farm Workers, 500-92-0037DO02.
- Federally Qualified Health Centers, 500-92-0037DO03.

92-082 **Medicaid Demonstration and Evaluation Support Projects: Master Contract: Research Triangle Institute** (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0033
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	James Lubalin, Ph.D.
Awardee:	Research Triangle Institute P.O. Box 12194 Research Triangle Park, NC 27709-2194
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount of the first DO, 500-92-0033DO02, Management Delivery Order is $52,099.

The individual DO projects awarded under the master contract are described in detail in the following sections of the *Status Report*.

Health Care Systems Reform and Financing

- Study of State Health Care Reform Initiatives, 500-92-0033DO03.

Managed Care Systems

- Evaluation of Medicaid-Managed Care Programs with 1915(b) Waivers, 500-92-0033DO02.

92-084 **Medicaid Demonstration and Evaluation Support Projects: Master Contract: SysteMetrics/MedStat** (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0035
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Marilyn Ellwood
Awardee:	SysteMetrics/MedStat 104 West Anapamu Street Santa Barbara, CA 93101
HCFA Project Officer:	Bonnie M. Edington Division of Health Systems and Special Studies

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0035DO01, Management Delivery Order is $41,151.

The individual DO project awarded under this master contract is described in detail in the following section of this *Status Report*.

Subacute and Long-Term Care

- Community-Supported Living Arrangements Program: Process Evaluation, 500-92-0035DO02.

92-081 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: Abt Associates Inc.** (Formerly, Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contracts)

Project No.:	500-92-0014
Period:	July 1992–July 1995
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in July 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0014DO01, Management Delivery Order is $33,137.

The individual DO projects awarded under this master contract are described in detail in the following sections of this *Status Report*.

Provider Payment

- Negotiated Surgical Episode Package Price Options for Services Within an Episode of Care: Feasibility and Strategy for Implementation under the Medicare Program, 500-92-0014DO03.

Subacute and Long-Term Care

- Community Nursing Organiztion Demonstration External Quality Assurance, 500-92-0014DO04.
- External Assessment of Quality Assurance in the Program of All-Inclusive Care for the Elderly, 500-92-0014DO02.

94-095 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: Brandeis University**

Project No.:	500-94-0043
Period:	September 1994–September 1995
Award:	Contract
Principal Investigator:	Stanley Wallack, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1994. This awardee is able to compete for individual delivery orders (DO) for 12 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 12-month funding amount for the first DO, 500-94-0043DO01, Management Delivery Order is $10,530.

The individual DO project awarded under this master contract is described in detail in the following section of this *Status Report*.

Service Delivery Systems

- Medicare End Stage Renal Disease Capitation Demonstration, 500-94-0043DO02.

92-080 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: Health Economics Research, Inc.** (Formerly, Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contracts)

Project No.:	500-92-0013
Period:	July 1992–July 1995
Award:	Contract
Principal Investigator:	Jerry Cromwell, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in July 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0013DO01, Management Delivery Order is $53,898.

The individual DO project awarded under this master contract is described in detail in the following section of this *Status Report*.

Provider Payment

- Medicare Participating Heart Bypass Center Demonstration Extended Evaluation, 500-92-0013DO03.

94-094 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: KPMG Peat Marwick**

Project No.:	500-94-0042
Period:	September 1994–September 1995
Award:	Contract
Principal Investigator:	Kathryn M. Langwell
Awardee:	KPMG Peat Marwick Policy Economics Group 2001 M Street, NW. Washington, DC 20036
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1994. This awardee is able to compete for individual delivery orders (DO) for 12 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 12-month funding amount for the first DO, 500-94-0042DO01, Management Delivery Order is $10,404.

This awardee has not been awarded any additional delivery orders.

92-079 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: Lewin/VHI, Inc.** (Formerly, Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contracts)

Project No.:	500-92-0012
Period:	July 1992–July 1995
Award:	Contract
Principal Investigator:	Allen Dobson, Ph.D.
Awardee:	Lewin/VHI, Inc. 9300 Lee Highway, Suite 400 Fairfax, VA 22031-1207
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in July 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0012DO01, Management Delivery Order is $29,751.

This awardee has not been awarded any additional delivery orders.

92-078 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: Mathematica Policy Research, Inc.** (Formerly, Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contracts)

Project No.:	500-92-0011
Period:	July 1992–July 1995
Award:	Contract
Principal Investigator:	Randall S. Brown, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Samuel L. Brown Division of Long-Term Care Experimentation

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in July 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0011DO01, Management Delivery Order is $34,951.

The individual DO projects awarded under this master contract are described in detail in the following sections of this *Status Report*.

Managed Care Systems

- Evaluation of the Cost of Health Maintenance Organizations and Health Care Prepayment Plans, 500-92-0011DO03.
- Evaluation of the Medicare Case Management Demonstrations, 500-92-0011DO02.

Provider Payment

- Physician Capitation for Medicare Services: Feasibility Study and Demonstration Design, 500-92-0011DO04.
- Medicare-Preferred Provider Organization, 500-92-0011DO05.

92-075 **Medicare Institutional/Facility-Based Services Demonstration Projects: Master Contract: Center for Health Policy Research** (Formerly, Medicare Institutional/Facility-Based Services Demonstration Projects: Master Contracts)

Project No.:	500-92-0046
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard Suite 706 Denver, CO 80222
HCFA Project Officer:	Victor G. McVicker Division of Hospital Experimentation

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare institutional/facility-based services demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0046DO01, Management Delivery Order is $50,846.

The individual DO project awarded under this master contract is described in detail in the following section of this *Status Report*.

Service Delivery Systems

- Analysis of Expansion of Access to Care through the Use of Telemedicine and Mobile Health Services, 500-92-0046DO02.

92-076 **Medicare Institutional/Facility-Based Services Demonstration Projects: Master Contract: Mathematica Policy Research, Inc.** (Formerly, Medicare Institutional/Facility-Based Services Demonstration Projects: Master Contracts)

Project No.:	500-92-0047
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Judith Wooldridge
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Victor G. McVicker Division of Hospital Experimentation

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare institutional/facility-based services demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0047DO01, Management Delivery Order is $38,706.

This awardee has not been awarded any additional delivery orders.

92-077 **Medicare Institutional/Facility-Based Services Demonstration Projects: Master Contract: University of Minnesota** (Formerly, Medicare Institutional/Facility-Based Services Demonstration Projects: Master Contracts)

Project No.:	500-92-0048
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	The University of Minnesota School of Public Health Institute for Health Services Research D-351 Mayo Memorial Building 420 Delaware Street, SE., Box 197 Minneapolis, MN 55455-0392
HCFA Project Officer:	Victor G. McVicker Division of Hospital Experimentation

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare institutional/facility-based services demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0048DO01, Management Delivery Order is $58,391.

The individual DO project awarded under this master contract is described in detail in the following section of this *Status Report*.

Subacute and Long-Term Care

- Improving the Discharge Planning Process, 500-92-0048DO02.

88-004 **Project HOPE Health Policy Research Center**

Project No.:	99-C-99168/3
Period:	January 1988–July 1993
Funding:	$ 3,632,741 (Total funds awarded for projects from January 1988 through July 1993)
Award:	Cooperative Agreement
Principal Investigator:	Karen Stewart
Awardee:	The People-to-People Health Foundation, Inc. Center for Health Affairs 7500 Old Georgetown Road, Suite 600 Bethesda, MD 20814-6133
HCFA Project Coordinator:	Leslie A. Mangels Office of Operations Support

Description: On November 19, 1987, Project HOPE's (Health Opportunity for People Everywhere) application as a research center for the Health Care Financing Administration (HCFA) was approved. The cooperative agreement was in effect through July 30, 1993. Under this cooperative agreement, the three major subcontractors to Project HOPE are the Vanderbilt University Health Policy Center; Medical College of Virginia Williamson Institute; and Social and Scientific Systems, Inc.

Status: Each year, Project HOPE Health Policy Research Center and HCFA jointly developed an agenda of specific topics and projects. The Center completed its fourth and final year on July 31, 1993. This edition of the *Status Report* describes the status of some projects conducted during that final year. The project titles, for which full descriptions are contained in the following sections, are:

Provider Payment

- Billing Patterns for Critical-Care Physician Services.
- Examination of Alternative Approaches for Graduate Medical Education Payment through Medicare: Continuation of Prior Study.
- Statistical Properties of Physician Practice Cost Surveys.

Access and Quality of Care

- Analysis of Medicare Expenditures for Ambulance Services.
- Beneficiary Access to and Utilization of Physician Services: Developing Baseline and Followup Measures for Assessing Physician Payment Reform.
- Technology Change, Medicare Volume Performance Standards, and Medicare Expenditure Growth.

Subacute and Long-Term Care

- Study of Medicare Home Health Agency Use of the Home Health "Case Management" Benefit.

84-003 The RAND/University of California, Los Angeles/Harvard Health Care Financing Policy Research Center

Project No.:	99-C-98489/9
Period:	March 1984–July 1993
Funding:	$ 13,508,386 (Total funds awarded for projects from March 1984 through July 1993)
Award:	Cooperative Agreement
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Coordinator:	Michael J. Baier Office of Operations Support

Description: The primary responsibility of the RAND/University of California, Los Angeles (UCLA)/Harvard Health Care Financing Policy Research Center was to provide expert consultation in planning, implementing, and evaluating research and demonstrations studies related to the ongoing functioning of the Medicare and Medicaid programs. The RAND Corporation was the principal partner organization for the Research Center. The UCLA School of Public Health and Harvard University's Division of Health Policy Research and Education affiliated with RAND as subcontractors under the cooperative agreement. The Center provided support and expertise on priority initiatives in all major areas of program activity.

Status: Each year, the RAND/UCLA/Harvard Research Center and the Health Care Financing Administration jointly developed an agenda of specific topics and projects. The Center completed its eighth and final year on July 30, 1993. This edition of the *Status Report* describes the status of some projects conducted during that final year. The project titles, for which full descriptions are contained in the following sections, are:

Access and Quality of Care

- Access to Kidney Transplant Waiting List.
- Center Billings for Ancillary Dialysis Services.
- Rates of Inpatient and Outpatient Shunt Procedures for End Stage Renal Disease Beneficiaries.

Program Statistics

- Medicaid Data Needs.

93-086 Research Centers: Master Contract: Abt Associates Inc. (Formerly, Research Centers: Master Contracts)

Project No.:	500-93-0029
Period:	September 1993–September 1995
Award:	Contract
Principal Investigator:	William D. Marder, Ph.D.
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Leslie A. Mangels Division of Program Support

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these projects demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1993. This awardee is able to compete for individual delivery orders (DO) until September 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for this first DO, 500-93-0029DO01, Management Delivery Order is $20,261.

The individual DO project awarded under this master contract is described in detail in the following section of this *Status Report*.

Provider Payment

- Evaluating Methods of Estimating Hospital Efficiency, 500-93-0029DO02.

93-087 Research Centers: Master Contract: Battelle Memorial Institute (Formerly, Research Centers: Master Contracts)

Project No.:	500-93-0030
Period:	September 1993–September 1995
Award:	Contract
Principal Investigator:	Bryan Luce, Ph.D.
Awardee:	Battelle Memorial Institute Public Health Research and Evaluation 4000 NE. 41st Street Seattle, WA 98105

HCFA Project Officer: Michael J. Baier
Division of Program Support

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1993. This awardee is able to compete for individual delivery orders (DO) until September 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for this first DO, 500-93-0030DO01, Management Delivery Order is $28,697.

This awardee has not been awarded any additional delivery orders.

92-087 **Research Centers: Master Contract: Health Economics Research, Inc.** (Formerly, Research Centers: Master Contracts)

Project No.:	500-92-0020
Period:	August 1992–August 1995
Award:	Contract
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. (HERI) 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Michael J. Baier Division of Program Support

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. This awardee is able to compete for individual delivery orders (DO) until August. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for this first DO, 500-92-0020DO01, Management Delivery Order is $38,911.

The individual DO projects awarded under this master contract are described in detail in the following sections of this *Status Report*.

Health Care Systems Reform and Financing

- Evaluation of Global Budgeting Strategies, 500-92-0020DO03.
- State Primer on All-Payer Systems for Health Care Services, 500-92-0020DO04.
- Update and Revision of the Continuous Update Diagnostic Cost Group Model, 500-92-0020DO06.
- Use of Medicare Physician Payment Methodologies and Cost-Containment Strategies by Medicaid Programs and Private Payers, 500-92-0020DO02.

Provider Payment

- Assessment and Redesign of Medicare Fee Schedule Areas (Localities), 500-92-0020DO09.
- Prospective Per Case Payment for Episodes of Hospital Care, 500-92-0020DO07.
- Unique Physician Identification Number Validation Studies, 500-92-0020DO05.

Access and Quality of Care

- Estimating Mammography Utilization by Elderly Medicare Women for Whom the Health Care Financing Administration Does Not Receive Administrative Claims, 500-92-0020DO11.

Program Statistics

- Patterns of Utilization and Expenditures for Prescription Drugs in Selected State Medicaid Programs, 500-92-0020DO08.

93-088 **Research Centers: Master Contract: KPMG Peat Marwick** (Formerly, Research Centers: Master Contracts)

Project No.:	500-93-0031
Period:	September 1993–September 1995
Award:	Contract
Principal Investigator:	Kathryn M. Langwell
Awardee:	KPMG Peat Marwick Policy Economics Group 2001 M Street, NW. Washington, DC 20036
HCFA Project Officer:	Michael J. Baier Division of Program Support

Description: This master contracts provides for the design, development, and conduct of research center

projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1993. This awardee is able to compete for individual delivery orders (DO) until September 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for the first DO, 500-93-0031DO01, Management Delivery Order is $30,360.

The individual DO project awarded under this master contract is described in detail in the following section of this *Status Report*.

Health Care Systems Reform and Financing

- Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment: KPMG Peat Marwick, 500-93-0031DO02.

92-088 **Research Centers: Master Contract: Lewin/VHI, Inc.** (Formerly, Research Centers: Master Contracts)

Project No.:	500-92-0021
Period:	August 1992–August 1995
Award:	Contract
Principal Investigator:	Allen Dobson, Ph.D.
Awardee:	Lewin/VHI, Inc. 9300 Lee Highway, Suite 500 Fairfax, VA 22031-1207
HCFA Project Officer:	Leslie A. Mangels Division of Program Support

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. This awardee is able to compete for individual delivery orders (DO) until August 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for the first DO, 500-92-0021DO01, Management Delivery Order is $24,044.

The individual DO projects awarded under this master contract are described in detail in the following sections of this *Status Report*.

Health Care Systems Reform and Financing

- Developing Methodologies for Assessing the Effectiveness of Medicare Parts A and B Medical Review, 500-92-0021DO03.
- Development and Testing of Risk Adjusters Using Medicare Inpatient and Ambulatory Data, 500-92-0021DO02.
- Development of a Risk-Adjustment System under Health Reform: Lewin/VHI, Inc., 500-92-0021DO05.

Access and Quality of Care

- Study of the Natural History of End Stage Renal Disease in Persons with Diabetes, 500-92-0021DO04.

94-115 **Research Centers: Master Contract: Michigan Public Health Institute**

Project No.:	500-94-0064
Period:	September 1994–September 1995
Award:	Contract
Principal Investigator:	William Weissert, Ph.D.
Awardee:	Michigan Public Health Institute 2465 Woodlake Circle, Suite 140 Okemos, MI 48864
HCFA Project Officer:	Michael J. Baier Division of Program Support

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1994. This awardee is able to compete for individual delivery orders (DO) until September 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for the first DO, 500-94-0064DO01, Management Delivery Order is $8,416.

This awardee has not been awarded any additional delivery orders.

92-090 **Research Centers: Master Contract: The RAND Corporation** (Formerly, Research Centers: Master Contracts)

Project No.:	500-92-0023
Period:	August 1992–August 1995
Award:	Contract
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The RAND Corporation Health Sciences Program 1700 Main Street, P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Michael J. Baier Division of Program Support

Description: This master contracts provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. This awardee is able to compete for individual delivery orders (DO) until August 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for the first DO, 500-92-0023DO01, Management Delivery Order is $64,244.

The individual DO projects awarded under this master contract are described in detail in the following sections of this *Status Report*.

Health Care Systems Reform and Financing

- Development of a Risk Adjustment System under Health Reform: The RAND Corporation, 500-92-0023DO09.
- State Legislative Initiatives, 500-92-0023DO05.
- Use of Medicare Hospital Payment Methodologies by Medicaid Programs and Private Payers, 500-92-0023DO04.

Provider Payment

- Assessment of Policies for Transfer Cases and Outlier Cases, 500-92-0023DO02.
- Examination of Alternative Methods for Calculating Relative Values for Practice Expense: The RAND Corporation, 500-92-0023DO06.

Access and Quality of Care

- Design of a Cost-Effectiveness Protocol for the Morbidity and Mortality in Hemodialysis Clinical Trials, 500-92-0023DO07.
- Evaluation of Capitation Payment for End Stage Renal Disease Services, 500-92-0023DO03.

92-089 **Research Centers: Master Contract: University of Minnesota** (Formerly, Research Centers: Master Contracts)

Project No.:	500-92-0022
Period:	August 1992–August 1995
Award:	Contract
Principal Investigator:	Jon Christianson, Ph.D.
Awardee:	The University of Minnesota Institute for Health Services Research School of Public Health, Box 729 420 Delaware Street, SE. Minneapolis, MN 55455-0392
HCFA Project Officer:	Michael J. Baier Division of Program Support

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. This awardee is able to compete for individual delivery orders (DO) until August 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for the first DO, 500-92-0022DO01, Management Delivery Order is $43,150.

The individual DO projects awarded under this master contract are described in detail in the following sections of this *Status Report*.

Provider Payment

- Examination of Alternative Methods for Calculating Relative Values for Practice Expense: The University of Minnesota, 500-92-0022DO02.

Access and Quality of Care

- Assessment of the Impact of the Medicaid Drug Rebate Policy on Expenditures, Utilization, and Access, 500-92-0022DO03.
- Multistate Analysis of Utilization, Expenditures, and Access to Care for Persons with Acquired Immunodeficiency Syndrome, 500-92-0022DO04.

94-116 Research Centers: Master Contract: University of Wisconsin-Madison

Project No.:	500-94-0065
Period:	September 1994–September 1995
Award:	Contract
Principal Investigator:	David R. Zimmerman, Ph.D.
Awardee:	University of Wisconsin-Madison Research Administration-Financial 750 University Avenue Madison, WI 53706-1490
HCFA Project Officer:	Leslie A. Mangels Division of Program Support

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1994. This awardee is able to compete for individual delivery orders (DO) until September 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for this first DO, 500-94-0064DO01, Management Delivery Order is $10,982.

This awardee has not been awarded any additional delivery orders.

92-091 Research Centers: Master Contract: The Urban Institute (Formerly, Research Centers: Master Contracts)

Project No.:	500-92-0024
Period:	August 1992–August 1995
Award:	Contract
Principal Investigator:	John Holahan, Ph.D.
Awardee:	The Urban Institute Health Policy Center 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Leslie A. Mangels Division of Program Support

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. This awardee is able to compete for individual delivery orders (DO) until August 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall funding amount for the first DO, 500-92-0024DO01, Management Delivery Order is $36,228.

The individual DO projects awarded under this master contract are described in detail in the following sections of this *Status Report*.

Health Care Systems Reform and Financing

- Assessing the Viability of Developing All-Payer Systems for Health Care Services: The Urban Institute, 500-92-0024DO04.
- Issues Involved in Developing a Standardized Benefit Package, 500-92-0024DO05.
- Options for Federal Funding for State Costs under Health Care Reforms, 500-92-0024DO06.

Provider Payment

- Research Plan for Hospital Payment Policy Interactions, 500-92-0024DO02.

Access and Quality of Care

- Uniform Clinical Data Set Algorithm Refinement Project, 500-92-0024DO07.

87-012 **Technical Support: Evaluation of Demonstrations: Abt Associates Inc.** (Formerly, Technical Support: Evaluation of Demonstrations)

Project No.:	500-87-0030
Period:	June 1987–June 1992
Award:	Contract
Principal Investigator:	William D. Marder, Ph.D.
Awardee:	Abt Associates Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Nancy A. Miller, Ph.D. Division of Long-Term Care Experimentation

Description: The Health Care Financing Administration (HCFA) awarded indefinite quantity contracts (IQC) to Abt Associates Inc. These contracts were designed to assist HCFA in evaluating demonstrations through the use of small scale tasks that can be awarded within short timeframes.

Status: The IQCs have expired. However, many of the individual delivery orders under these IQCs have been converted into stand alone contracts. The delivery orders for Abt Associates Inc. that have not expired are described in the following sections of this *Status Report*.

Managed Care Systems

- Evaluation of United Mine Workers of America Demonstration.

Provider Payment

- Medicare Cataract Surgery Alternate Payment Demonstration.
- Staff-Assisted Home Dialysis Demonstration.

Access and Quality of Care

- Evaluation of the Medicaid Extension Demonstrations.

Service Delivery Systems

- Expanded Cross-Cutting Evaluation of Medicare Prevention Demonstrations under the Consolidated Omnibus Budget Reconciliation Act.

87-011 **Technical Support: Evaluation of Demonstrations: Lewin/VHI, Inc.** (Formerly, Technical Support: Evaluation of Demonstrations)

Project No.:	500-87-0029
Period:	June 1987–June 1992
Award:	Contract
Principal Investigator:	Robert J. Rubin, M.D.
Awardee:	Lewin/VHI, Inc. 9300 Lee Highway, Suite 400 Fairfax, VA 22031-1207
HCFA Project Officer:	Nancy A. Miller, Ph.D. Division of Long-Term Care Experimentation

Description: The Health Care Financing Administration (HCFA) awarded indefinite quantity contracts (IQC) to Lewin/VHI, Inc. These contracts were designed to assist HCFA in evaluating demonstrations through the use of small scale tasks that can be awarded within short timeframes.

Status: The IQCs have expired. However, many of the individual delivery orders under these IQCs have been converted into stand alone contracts. The delivery orders for Lewin/VHI, Inc., that have not expired are described in the following sections of this *Status Report*.

Provider Payment

- Evaluation of the Ventilator-Dependent Unit Demonstration.
- Medicare Participating Heart Bypass Center Demonstration.

87-010 **Technical Support: Evaluation of Demonstrations: Mathematica Policy Research, Inc.** (Formerly, Technical Support: Evaluation of Demonstrations)

Project No.:	500-87-0028
Period:	June 1987–June 1992
Award:	Contract
Principal Investigator:	Harold S. Beebout, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Nancy A. Miller, Ph.D. Division of Long-Term Care Experimentation

Description: The Health Care Financing Administration (HCFA) awarded indefinite quantity contracts (IQC) to Mathematica Policy Research, Inc. These contracts were designed to assist HCFA in evaluating demonstrations through the use of small scale tasks that can be awarded within short timeframes.

Status: The IQCs have expired. However, many of the individual delivery orders under these IQCs have been converted into stand alone contracts. The delivery orders for Mathematica Policy Research, Inc., that have not expired are described in the following sections of this *Status Report*.

Managed Care Systems

- Evaluation of the Municipal Health Services Program.

Provider Payment

- Evaluation of the Physician Preferred Provider Organization Demonstration.

Access and Quality of Care

- Evaluation of Demonstration to Provide Medicaid Coverage for Human Immunodeficiency Virus-Positive Individuals.
- Rural Health Transition Grant Evaluation: 1991-92.

Source Delivery Systems

- Evaluation of the Essential Access Community Hospital/Rural Primary Care Hospital Program.

88-003 University of Minnesota Research Center

Project No.:	99-C-99169/5
Period:	January 1988–April 1993
Funding:	$ 4,122,426 (Total funds awarded for projects from January 1988 through April 1993)
Award:	Cooperative Agreement
Principal Investigator:	Roger D. Feldman, Ph.D.
Awardee:	The University of Minnesota 1919 University Avenue St. Paul, MN 55415-1226
HCFA Project Officer:	Michael J. Baier Office of Operations Support

Description: On November 19, 1987, the University of Minnesota's application as a research center for the Health Care Financing Administration (HCFA) was approved. The cooperative agreement was in effect through April 30, 1993. The University of Pennsylvania and Mathematica Policy Research, Inc., were two major subcontractors affiliated with the University of Minnesota under this cooperative agreement.

Status: Each year, the University of Minnesota Research Center and HCFA jointly developed an agenda of specific topics and projects. The Center completed its fourth and final year on April 30, 1993. This edition of the *Status Report* describes the status of some projects conducted during that final year. The project titles, for which full descriptions are contained in the following sections, are:

Provider Payment

- Diagnostic Testing: Policy Analysis of Pricing Options.
- Efficient Volume Pricing of the Technical Component for Diagnostic Procedures.
- Volume-Adjusted Payment for Clinical Laboratory Services.

Topical Index

Alphabetical Index of Research and Demonstration Projects

Health Care Systems Reform and Financing

Managed Care Systems

Provider Payment

Access and Quality of Care

Service Delivery Systems

Subacute and Long-Term Care

Consumer Information

Program Statistics

Master Contracts and Research Centers

Index of Awardee Organizations

Burger, Carroll and Associates, Inc.
1442-B St. Francis Drive
Santa Fe, NM 87501 71

California Department of Health Services
714/744 P Street
P.O. Box 942732
San Francisco, CA 94234-7320 167, 171

California Department of Social Services
744 P Street
Sacramento, CA 95814 88, 66

CAPP CARE, Inc.
West Tower
4000 MacArthur Boulevard, Suite 10000
Newport Beach, CA 92660-2526 57

Carle Clinic Association
307 East Oak, Suite 3
P.O. Box 718
Mahomet, IL 61853 132, 157

Carnegie Mellon University
5000 Forbes Avenue
Pittsburgh, PA 15213 21

Carondelet Health Services, Inc.
Carondelet St. Mary's Hospital
1601 West St. Mary's Road
Tucson, AZ 85745 133

Cataract Eye Center of Cleveland, Inc.
2322 East 22nd Street, Suite 307
Cleveland, OH 44115 50

Catherine McAuley Health System
5301 East Huron River Drive
Ann Arbor, MI 48106 53

Centers for Disease Control
National Center for Health Statistics
6325 Belcrest Road, Room 850
Hyattsville, MD 20782 164

Center for Health Economics Research
300 Fifth Avenue, 6th Floor
Waltham, MA 02154 8, 6, 62, 5, 85, 44

Center for Health Policy Research
1355 South Colorado Boulevard, Suite 706
Denver, CO 80222 113, 209, 189, 137, 156, 138

Center for Health Policy Research
Institute for Policy Research and Evaluation
Pennsylvania State University
Office of Sponsored Programs
110 Technology Center
University Park, PA 16802 195

Center for Health Policy Studies
9700 Patuxent Woods Drive
Columbia, MD 21046 61, 49

Center for Health Systems Research and Analysis University of Wisconsin
750 University Avenue
Madison, WI 53706 197

Center for Health Systems Research and Analysis University of Wisconsin-Madison
Room 1163, WARF Office Building
610 Walnut Street
Madison, WI 53705 196

Cincinnati Area Senior Services, Inc.
644 Linn Street, Suite 1017
Cincinnati, OH 45203 158

The Circle, Inc.
8201 Greensboro Drive, Suite 600
McLean, VA 22102 150

City of Baltimore
111 North Calvert Street
Baltimore, MD 21202 27

City of Cincinnati
3101 Burnet Avenue
Cincinnati, OH 45229 28

City of Milwaukee
841 North Broadway
Milwaukee, WI 53202 28

City of San Jose
151 West Mission Street
San Jose, CA 95110 29

Colorado Department of Health
Rural and Primary Health Policy and Planning
4300 Cherry Creek Drive, South
Denver, CO 80222-1530 118

Colorado Department of Human Services
1575 Sherman Street
Denver, CO 80203-1714 67

Colorado Department of Social Services
1575 Sherman Street
Denver, CO 80203-1714 171

Columbia Cascade, Inc.
12030 Sunrise Valley Drive, Suite 440
Reston, VA 22091-3409 79

Community Care Organization
5228 West Fond du Lac Avenue
Milwaukee, WI 53216 172

Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033 69

Credential Assurance Group of America
2650 Woodley Place, NW.
Washington, DC 20008 25

DataChron Health Systems
763 Massachusetts Avenue, Suite 7
Boston, MA 02139 31, 149, 1

Delaware Department of Health and
Social Services
1901 North DuPont Highway
New Castle, DE 19720 78

Dolley, Keniston, & Webb
1021 Burnham Road, Suite 727
Gorham, ME 04038 100

East Boston Geriatric Services, Inc.
10 Gove Street
Boston, MA 02128 173

East Carolina University
Greenville, NC 27858 127

ECRI
5200 Butler Pike
Plymouth Meeting, PA 19462 87

Elderplan, Inc.
6323 Seventh Avenue
Brooklyn, NY 11220 186

Florida Agency for Health Care
Administration
1317 Winewood Boulevard
Building 5, Room 422
Tallahassee, FL 32399-0700 101

Florida Agency for Health Care
Administration
1317 Winewood Boulevard
Building 6, Room 271
Tallahassee, FL 32399-0700 90

Florida Department of Health and
Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, FL 32399-0700 82

Florida's Agency for Health Care
Administration
The Atrium
325 John Cox Road, Suite 301
Tallahassee, FL 32303-4131 8

Georgetown University
Center for Health Policy Studies
2233 Wisconsin Avenue, NW., Suite 525
Washington, DC 20007 63

Georgetown University
Division of Community Health Studies and
Family Medicine
3750 Reservoir Road, NW.
Washington, DC 20007-2197 169

Gerontology Center
College of Health and Human Development
Penn State University
210 Henderson Building South
University Park, PA 16802 86

Good Samaritan Hospital and Medical Center
1015 Northwest 22nd Avenue
Portland, OR 97210 158

Government of the District of Columbia
Commission on Health Care Finance
2100 Martin Luther King Jr. Avenue, SE.
Suite 302
Washington, DC 20020 155

Harvard Medical School
25 Shattuck Street
Boston, MA 02115 13

Hawaii Department of Human Services
P.O. Box 339
Honolulu, HI 96809-0339 9

Health Economics Research, Inc. (HERI)
300 Fifth Avenue, 6th Floor
Waltham, MA 02154 33, 43, 79, 207, 212, 203, 75, 62, 58, 54, 32, 18, 18, 14, 10, 7, 52, 7

Health Economics Research, Inc. (HERI)
Hillsite Office Building
75 Second Avenue, Suite 100
Needham, MA 02194 34

Health Policy Center
Vanderbilt University
Box 1503–Station B
Nashville, TN 37235 45

Health Systems Research, Inc.
2385 Garden Highway
Sacramento, CA 95833 114

HealthPartners and Ebenezer Society
8100 34th Avenue South
Minneapolis, MN 55440-1309 186

Hebrew Rehabilitation Center for the Aged
1200 Centre Street
Boston, MA 02131 141

Highland General Hospital
1411 East 31st Street
Oakland, CA 94608 74

HK Research Corporation
477 White Plains Court
Severna Park, MD 21146 58

Illinois Department of Public Aid
100 South Grand Avenue East
Springfield, IL 62762-0001 84

Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, IL 62763-0001 174

Institute for Health and Aging
University of California, San Francisco
201 Filbert Street
Box 0646, Laurel Heights
San Francisco, CA 94133-0646 144, 143

Institute of Gerontology
University of Michigan
300 North Ingalls Building, Room 900
Ann Arbor, MI 48109-2007 132

Instituto de Administracion y
Politica de Salud de Puerto Rico
P.O. Box 193745
Hato Rey, PR 00919-3745 3

Iowa Foundation for Medical Care
6000 Westown Parkway, Suite 350E
West Des Moines, IA 50265-7771 25

Iowa Methodist Health System
1200 Pleasant Street
Des Moines, IA 50309 121

IV Systems, Inc.
131 Forest Street
Winchester, MA 01890 66, 101

James C. Beebe
1345 Tydings Road
Annapolis, MD 21401 60, 59

John Deere and Company
John Deere Road
Moline, IL 61265 26

John Rafferty and Associates
14012 North 80th Place
Scottsdale, AZ 85260 79

The Johns Hopkins University
Program for Medical Technology and
Practice Assessment
1830 East Monument Street, Room 8061
Baltimore, MD 21205 103

The Johns Hopkins University
School of Hygiene and Public Health
624 North Broadway
Baltimore, MD 21205 124

The Johns Hopkins University
School of Medicine
720 Rutland Avenue
Baltimore, MD 21205 85, 68

Kaiser Foundation Research Institute
3505 Broadway, Suite 1112
Oakland, CA 94611 20

Massachusetts General Hospital
Children's Service
Fruit Street, WACC 715
Boston, MA 02114 67

Mathematica Policy Research, Inc.
600 Maryland Avenue, SW., Suite 550
Washington, DC 20024-2512 70, 205, 81, 5, 8

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393 105, 23, 122, 104, 209, 113, 54, 142, 216, 123, 77, 41, 76, 208, 56, 23, 21, 140

Mayo Foundation
St. Mary's Hospital
Rochester, MN 55905 37

Mecon Associates
200 Porter Place, Suite 100
San Ramon, CA 94583 74

The Medical Center of Beaver, PA, Inc.
1000 Dutch Ridge Road
Beaver, PA 15009 25

Medical Eye Associates, Inc.
7003 Pearl Road
Middleburg Heights, OH 44130 50

Medical Horizons, Inc.
136 Dwight Road
Longmeadow, MA 01106 76

The Medical Technology and
Practice Patterns Institute
2121 Wisconsin Avenue, Suite 230
Washington, DC 20007 203

Mercy Foundation
Sixth and University
Des Moines, IA 50314 126

Methodist Hospital of Indiana, Inc.
1701 North Senate Boulevard
Indianapolis, IN 46206-1367 53

Miami Jewish Home and Hospital for
the Aged
151 Northeast 52nd Street
Miami, FL 33137 151

Miami Valley Hospital
One Wyoming Street
Dayton, OH 45409 159

Michigan Department of Social Services
400 South Pine Street
Lansing, MI 48909 91

Michigan Department of Social Services
235 South Grand Avenue
P.O. Box 30037
Lansing, MI 48909 106

Michigan Public Health Institute
2465 Woodlake Circle, Suite 140
Okemos, MI 48864 213

Mikalix and Company
404 Wyman Street, Suite 375
Waltham, MA 02154 81

Minnesota Department of Health
Office of Rural Health
717 Delaware Street Southeast
P.O. Box 9441
Minneapolis, MN 55440-9441 15

Minnesota Department of Human Services
Health Care Administration
44 Lafayette Road
St. Paul, MN 55155-3853 183

Minnesota Department of Public Welfare
2nd Floor–Space Center
444 Lafayette Road
St. Paul, MN 55101 27

Minnesota Mining and Manufacturing Company
Health Information Systems
St. Paul, MN 55144-1000 39

Mississippi Division of Medicaid
239 North Lamar, Suite 801
Jackson, MS 39211 16

Monroe County Long Term Care
Program, Inc.
349 West Commercial Street, Suite 2250
Piano Works
East Rochester, NY 14445 160, 184

Montana Hospital Research and
Education Foundation
P.O. Box 5119
Helena, MT 59604 93

National Association for Equal Opportunity in
Higher Education
Black Higher Education Center
Lovejoy Building
400 12th Street, NE.
Washington, DC 20002 165

The National Institute of Diabetes and
Digestive and Kidney Diseases
c/o: Larry Agadoa, M.D.
Building 31
31 Center Drive, MSC 2560
Bethesda, MD 20892-2560 73

National Institute on Aging
9000 Rockville Pike
Bethesda, MD 20892 154

National Medical Enterprises
Doctors Hospital of Dallas
9440 Poppy Drive
Dallas, TX 75218 50

Nebraska Department of Health
Division of Health Policy and Planning
301 Centennial Mall South
P.O. Box 95007
Lincoln, NE 68509-5007 16

Network Design Group, Inc.
1000 Pittsford-Victor Road
Pittsford, NY 14534 20

New England Research Institute, Inc.
9 Galen Street
Watertown, MA 02172 183

New Jersey Department of Human Services
CN 700
Trenton, NJ 08625-0700 97

New York State Department of Health
Empire State Plaza
Room 1683 Corning Tower
Albany, NY 12237 166

New York State Department of Social Services
40 North Pearl Street
Albany, NY 12243-0001 202, 176, 175

New York State Department of Social Services
Division of Medical Assistance
40 North Pearl Street
Albany, NY 12243 115

North Carolina Department of
Human Resources
Office of Rural Health and
Resource Development
311 Ashe Avenue
Raleigh, NC 27606 119, 17

Northeast Alzheimer's Consortium
1330 Sycamore View, Suite 2
Memphis, TN 38314 161

Office of Governor
Division of Medicaid
Robert E. Lee Building, Suite 801
239 North Lamar Street
Jackson, MS 39201 163

Office of Statewide Health Planning and
Development
Division of Health Projects and Analysis
1600 9th Street, Room 440
Sacramento, CA 95814 117

The Ohio State University Hospitals
450 West 10th Avenue
Columbus, OH 43210-1228 54

On Lok, Inc.
1333 Bush Street
San Francisco, CA 94109 172

On Lok Senior Health Services
1333 Bush Street
San Francisco, CA 94109 167

Oregon Department of Human Resources
500 Summer Street, NE.
Salem, OR 97310 11

Oregon State Department of Human Services
313 Public Service Building
Salem, OR 97310 176

Patient Care Pharmacy, Inc.
6300 Arizona Circle
Los Angeles, CA 90045 68

The People-to-People
Health Foundation, Inc.
Center for Health Affairs
7500 Old Georgetown Road, Suite 600
Bethesda, MD 20814-6133 32, 22, 99, 95, 84, 210, 190, 106, 65, 64, 61, 42

Pharmacon International, Inc.
350 Fifth Avenue, Suite 5110
New York, NY 10118 87

President and Fellows of Harvard College
Harvard School of Public Health
1350 Massachusetts Avenue
Holyoke Center, 4th Floor
Cambridge, MA 02138 51

Providence Hospital
16001 West Nine Mile Road
Southfield, MI 48045 19

Providence Medical Center
4805 Northeast Glisan Street
Portland, OR 97213 177

The RAND Corporation
1700 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138 86, 73, 72, 3, 47, 211, 102, 66, 64, 202

The RAND Corporation
2100 M Street, NW.
Washington, DC 20037 92

The RAND Corporation
Health Sciences Program
1700 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138 214, 76, 71, 42, 31, 18, 14, 5

Research Triangle Institute
P.O. Box 12194
Research Triangle Park, NC 27709-2194 205, 22, 17, 198, 199, 23

Research Triangle Institute
P.O. Box 12194
3040 Cornwallis Road
Research Triangle Park, NC 27709 113

Reshet, Inc.
314 North 32nd Street
Philadelphia, PA 19104-2504 99

Richland Memorial Hospital
Fifteen Richland Medical Park
Columbia, SC 29203 178

RMS Health Providers
Joint Venture of Suburban Hospital/Rush
Presbyterian Hospital
Hinsdale, IL 60521 36

Rochester General Hospital
311 Alexander Street
Rochester, NY 14604 178

Rush University
1653 West Congress Parkway
Chicago, IL 60612-3833 83

Saint Joseph's Hospital of Atlanta
5665 Peachtree Dunwoody Road, NE.
Atlanta, GA 30342-1701 52

San Diego State University Foundation
Graduate School of Public Health
San Diego State University
San Diego, CA 92182-1900 124

SCAN Health Plan
521 East Fourth Street
Long Beach, CA 90802 187

ScienTech, Inc.
SE. 1122 Latah Street
Pullman, WA 99163 128

Scientific Associates
1349 South Street
Rochester, NY 14620 97

Shepard Patterson
Government Systems Division
8300 Colesville Road, Suite 350
Silver Springs, MD 20910 82

Sinai Hospital of Detroit
Detroit, MI 48235 37

South Carolina State Health and
Human Services
Finance Commission
P.O. Box 8206
Columbia, SC 29202-8206 80, 179, 90, 115

South Dakota Department of Health
Office of Rural Health
445 East Capitol Avenue
Pierre, SD 57501-3185 120

South Dakota Department of Social Services
Office of Adult Services and Aging
700 Governors Drive
Pierre, SD 57501 164

Southwestern Eye Center, Ltd.
1818 East Southern Avenue, Suite 18
Mesa, AZ 85204 51

St. Luke's Episcopal Hospital
Texas Medical Center
6720 Bertner Street
Houston, TX 77030 54

St. Vincent Hospital and Medical Center
9155 SW. Barnes Road
Portland, OR 97225 54

State of Iowa
Division of Medical Services
East 13th and Walnut
Hoover Building, 5th Floor
Des Moines, IA 50319 71

State of Maine
State House Station 102
9 Green Street
Augusta, ME 04333 47

State of New York Department of Health
Office of Rural Health
Room 1656 Corning Tower
Empire State Plaza
Albany, NY 12237 119

State of Rhode Island
Department of Human Services
600 New London Avenue
Cranston, RI 02920 12

State of Washington
Department of Social and Health Studies
617 8th Avenue, SE.
Olympia, WA 98504-5510 89

State of Washington
Department of Social and Health Services
623 8th Avenue, SE.
Olympia, WA 98504-5510 99

Sutter Health System
2800 L Street
Sacramento, CA 95816 179

SysteMetrics/McGraw-Hill
104 West Anapamu Street
Santa Barbara, CA 93101 196

SysteMetrics/MedStat
104 West Anapamu Street
Santa Barbara, CA 93101 206, 135

SysteMetrics, Division of MedStat, Inc.
777 East Eisenhower Parkway, Suite 500
Ann Arbor, MI 48108 67

SysteMetrics, Inc.
Santa Barbara Corporate Center
5425 Hollister Avenue, Suite 140
Santa Barbara, CA 93111 101, 92, 202

Systems Management Associates
5427 Valkeith
Houston, TX 77096 101

Technovation Training, Inc.
Executive Court Professional Centers
3454 Oak Alley Court, Suite 209
Toledo, OH 43606-1317 83

TechnoView, Inc.
98 Baycrest Court
Newport Beach, CA 92660-8922 69

Telemedicine Research Center
7276 SW. Beaverton-Hillsdale Highway
Suite 187
Portland, OR 97225 128

Temple University Hospital
Philadelphia, PA 19140 38

Tennessee Department of Health
TennCare Bureau
344 Cordell Hull Building
Nashville, TN 37247-0101 17

Texas Department of Human Services
P.O. Box 149030 (MC-E-601)
Austin, TX 78714-9030 180, 194

Total Longterm Care, Inc.
3202 West Colfax
Denver, CO 80204 181

Umoja Care, Inc.
4501 West Augusta Boulevard
Chicago, IL 60651 181

UMWA Health and Retirement Funds
2021 K Street, NW.
Washington, DC 20006 30

United HealthCare Corporation, Inc.
P.O. Box 1459
Minneapolis, MN 55440-8001 155

University of California
School of Public Health
10833 Le Conte Avenue
Los Angeles, CA 90024-1772 125

University of California, Los Angeles
School of Public Health
1100 Glendon Avenue, Suite 711
Los Angeles, CA 90024-3511 82

University of California, San Francisco
Office of Research Affairs
3333 California Street, Suite 11
San Francisco, CA 94143-0962 153

University of Colorado
Health Sciences Center
1355 South Colorado Boulevard
Denver, CO 80222 168

The University of Maryland at Baltimore
Center on Drugs and Public Policy
School of Pharmacy
511 West Lombard Street
Baltimore, MD 21201 84

The University of Maryland at Baltimore
Department of Pediatrics/General Practrics
511 West Lombard Street
Baltimore, MD 21201 91

The University of Michigan
3003 South State Street
Ann Arbor, MI 48109-1274 117

The University of Michigan
Department of Internal Medicine
Division of General Medicine
3116 Taubman Center
Ann Arbor, MI 48109-0376 33

The University of Michigan
Kidney Epidemiology and Cost Center
315 West Huron, Suite 420
Ann Arbor, MI 48103 75, 70

The University of Minnesota
1100 Washington Avenue South, Suite 201
Minneapolis, MN 55415-1226 24

The University of Minnesota
1919 University Avenue
St. Paul, MN 55415-1226 217, 63, 40

The University of Minnesota
Institute of Community Integration
150 Pillsbury Drive, SE.
Minneapolis, MN 55455 165

The University of Minnesota
Institute for Health Services Research
School of Public Health, Box 729
420 Delaware Street, SE.
Minneapolis, MN 55455-0392 214, 97, 65, 43, 210, 148, 30

The University of Minnesota
School of Public Health
704 Washington Avenue, SE., Suite 203
Minneapolis, MN 55414 190

The University of Minnesota
School of Public Health
Institute for Health Services Research
D-351 Mayo Memorial Building
420 Delaware Street, SE., Box 197
Minneapolis, MN 55455-0392 185, 100, 146

The University of Pennsylvania
School of Medicine
Philadelphia, PA 19104-6095 72

University of Pittsburgh
Department of Epidemiology
130 Desoto Street
Pittsburgh, PA 15261 125

University of South Florida
4202 Fowler Avenue
Tampa, FL 33620 47

University of Washington
School of Public Health and
Community Medicine
F346 Health Sciences Building SC37
Seattle, WA 98195 126

University of Wisconsin-Madison
Research Administration–Financial
750 University Avenue
Madison, WI 53706-1490 215

The Urban Institute
2100 M Street, NW.
Washington, DC 20037 94, 128, 46, 64, 39, 13, 79

The Urban Institute
Health Policy Center
2100 M Street, NW.
Washington, DC 20037 215, 59, 11, 10, 2

The Urban Medical Group
545 D Centre Street
Jamaica Plain, MA 02130 166

Utah Department of Human Services
P.O. Box 45500
Salt Lake City, UT 84145-0500 108

Vanderbilt University School of Medicine
21st and Garland
Nashville, TN 37232 73

Vermont Agency of Human Services
103 South Main Street
Waterbury, VT 05676 110

Virginia Commonwealth University
P.O. Box 980568
Richmond, VA 23298-0568 1

Virginia Department of
Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219 88

Virginia Department of Social Services
8007 Discovery Drive
Richmond, VA 23229-8699 110

Visiting Nurse Service of New York
107 East 70th Street
New York, NY 10021-5087 135

Washington State Department of Health
Office of Community and Rural Health
P.O. Box 47834
Olympia, WA 98504-7834 14

Washington State Department of Social and
Health Services
P.O. Box 45010
Olympia, WA 98504-5010 111

Washington State Department of Social and
Health Services
Office of First Steps
Mail Stop OB-45A
Olympia, WA 98504 116

Wellmark Healthcare Services, Inc.
60 William Street
Wellesley, MA 02181 185

West Virginia Bureau of Public Health
Office of Community and Rural Health Services
1411 Virginia Street, East
Charleston, WV 25301 120

West Virginia University Research Corporation
Office of Sponsored Programs
P.O. Box 6845
Morgantown, WV 26506-6845 113

Wisconsin State Department of Health and
Social Services
1 West Wilson Street
P.O. Box 309
Madison, WI 53701-0309 188

Wisconsin State Department of Health and
Social Services
P.O. Box 7850
Madison, WI 53707-7850 182, 112, 111

Wisconsin State Department of Health and

Social Services
P.O. Box 7935
Madison, WI 53707-7935 112

Wood County Senior Citizens Association, Inc.
925 Market Street
Parkersburg, WV 26101 161

Index of Principal Investigators and Project Directors

Geographical Index of Studies and Demonstrations

State-Specific Projects

International

Project Officers and Project Directors

Name	Area Code (410) and Telephone Number	Location
Adamo, Alisa	786-6618	C-3-18-25
Babish, Daniel J.	786-6607	C-3-12-26
Bae, Jay	786-6591	C-3-17-05
Baier, Michael J.	786-6664	C-3-24-03
Bandzwolek, Joanna K.	786-6643	C-3-11-26
Benedict, Beth M.	786-7724	C-3-25-24
Boben, Paul J.	786-6629	C-3-20-07
Brown, Samuel L.	786-6667	C-3-23-05
Buczko, William	786-6593	C-3-16-25
Connolly, Robert P.	786-6882	S-1-09-26
Cornelius, Elizabeth S.	786-6655	C-3-16-13
Cotterill, Philip G.	786-6598	C-3-15-27
Cramer, Joseph M.	786-6676	C-3-17-04
Damrosch, William L.	786-6678	C-3-16-23
Davis, Feather Ann	786-6590	C-3-22-26
Deacon, Ronald W.	786-6622	C-3-14-01
DeCaro, Teresa L.	786-6604	C-3-17-06
Dutton, Benson L.	786-6603	C-3-17-24
Edington, Bonnie M.	786-6617	C-3-20-14
Eggers, Paul W.	786-6691	C-3-24-08
England, William L.	786-0542	C-3-23-23
Fitterman, Leslye	786-7596	C-3-24-13
Freedman, Alvin L.	786-6597	C-3-21-01
Fried, Sherrie L.	786-6619	C-3-19-17
Friedman, Maria A.	786-9915	C-3-10-27
Gondek, Kathleen	786-7765	C-3-14-05
Goody, Brigid	786-6640	C-3-14-04
Greenberg, Barbara	786-6654	C-3-22-25
Greenwald, Leslie M.	786-6502	C-3-14-03
Greer, Joel W.	786-6695	C-3-24-04
Hackerman, Carl S.	786-6644	C-3-11-18
Hadley, James P.	786-6626	C-3-20-08
Hatten, Rose M.	786-6630	C-3-19-18
Helbing, Charles R.	786-7705	C-3-13-25
Henesch, Michael	786-6685	C-3-17-25
Hernandez-Albertini, Rosana	786-4175	C-3-25-04
Hirsch, Marilyn B.	786-7716	C-3-23-07
Hutton, Edward T.	786-6616	C-3-19-27
Ingber, Melvin J.	786-1913	C-3-15-26
Keene, Roger E.	786-7007	C-3-13-15
Kendix, Michael	786-6631	C-3-23-24
Kirby, G. Wilson	786-7710	C-3-24-25
Krause, Mark A.	786-6683	C-3-12-24
Kucken, Lawrence E.	786-6694	C-3-17-26
Lambert, Ronald W.	786-6624	C-3-14-13
Levy, Jesse M.	786-6600	C-3-16-06
Lewandowski, Kay	786-6657	C-3-23-04
Lubitz, James D.	786-6696	C-3-21-17
Mangels, Leslie A.	786-0494	C-3-12-05
Mason, Cynthia K.	786-6680	C-3-15-24
Mauser, Elizabeth	786-6665	C-3-21-16
Mazumdar, Siddhartha	786-6673	C-3-16-24
McBean, A. Marshall	786-6693	C-3-21-25
McMillan, Alma B.	786-6698	C-3-25-03
McNiff, Melissa	786-8494	C-3-22-15
McVicker, Victor G.	786-6681	C-3-14-14
Meadow, Ann	786-6602	C-3-17-23
Mentnech, Renee	786-6692	C-3-23-03
Miller, Nancy A.	786-6649	C-3-20-27
Miller, Sefan N.	786-6656	C-3-20-18
Nagy, Phyllis A.	786-6646	C-3-21-15
Nugent, Dennis M.	786-6663	C-3-21-14
O'Brien, Ellen	786-6662	C-3-22-05
O'Dougherty, Sheila M.	786-6568	C-3-26-26
Peden, Edgar A.	786-6594	C-3-16-15
Pine, Penelope L.	786-7718	C-3-24-24
Reilly, Thomas W.	786-2196	C-3-21-05
Riley, Gerald F.	786-6699	C-3-22-23
Rimes, Carolyn	786-6620	C-3-22-16
Sangl, Judith A.	786-6596	C-3-26-02
Savitt, Harry L.	786-6688	C-3-24-05
Silverman, Herbert A.	786-7702	C-3-16-14
Smiddy, Gloria	786-7733	C-3-19-26
Sobaski, William J.	786-6588	C-3-16-07
Terrell, Sherry A.	786-6601	C-3-18-03
Thoumaian, Armen H.	786-6672	C-3-14-25
Trontell, Anne A.	786-4709	C-3-21-26
Tudor, Cynthia G.	786-6499	C-3-22-03
Van Hoven, Deborah C.	786-6625	C-3-19-28
Walsh, David W.	786-6628	C-3-19-05
Warren, Joan L.	786-0677	C-3-23-25
Weisgrau, Sheldon D.	786-6675	C-3-17-03
Young, Kevin	786-6133	S-3-02-26

Publications Inquiries and Documentation Requests

Publication information and requests:

Executive Secretariat
Office of Research and Demonstrations
7500 Security Boulevard, C-3-11-07
Baltimore, Maryland 21244-1850
(410) 786-6584

Statistical inquiries:

Inquiries regarding the availability of statistical information, other than those pertaining to the specific contents of articles in the *Health Care Financing Review,* should be directed to the following components:

Medicare Statistics

Information Processing Branch
Division of Health Care Information Services
Office of Health Care Information Services
Bureau of Data Management and Strategy
7500 Security Boulevard, N-3-15-25
Baltimore, Maryland 21244-1850
(410) 786-3689

Medicaid Statistics

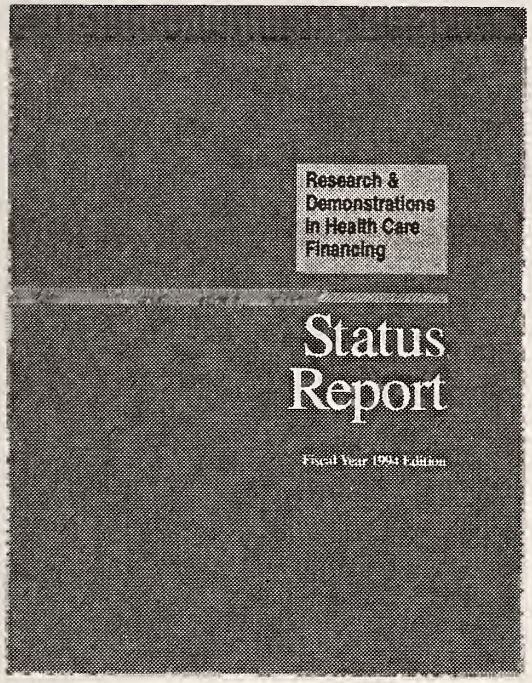
Medicaid Systems Branch
Office of Systems Management
Bureau of Data Management and Strategy
7500 Security Boulevard, N-3-15-25
Baltimore, Maryland 21244-1850
(410) 786-0165

Documentation requests:

Division of Health Care Information Services
Office of Health Care Information Services
Bureau of Data Management and Strategy
7500 Security Boulevard, N-3-15-25
Baltimore, Maryland 21244-1850
(410) 786-3691

☆ U.S. GOVERNMENT PRINTING OFFICE: 1995 – 386 - 697 / 33469

Your single source for updates on research and demonstration projects



Look no further than the *Status Report* for annual updates on research and demonstration activities that are financed by the Office of Research and Demostrations. We're the sole source of research findings with one single, unified goal...to provide current information on active intramural and extramural projects.

This year's edition contains several new features. These features consist of a keyword index, an alphabetical index of project titles, an index of awardee organizations, an index of principal investigators and HCFA project directors, a geographic index of projects by State, and a directory of project officers and directors.

To order your copy of this exciting edition, complete the following form and mail to: Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954.

Order your copy today!

Superintendent of Documents **Subscriptions** Order Form

Order Processing Code:

Charge your order It's Easy! MasterCard VISA

To fax your orders (202) 512-2250

☐ YES, enter my subscription(s) as follows:

_____ **issue(s) of the Research and Demonstrations in Health Care Financing Status Report, 1994 Edition**

The total cost of my order is $_____. International customers please add 25%. Prices include regular domestic postage and handling and are subject to change.

(Company or Personal Name) (Please type or print)

(Additional address/attention line)

(Street address)

(City, State, ZIP Code)

(Daytime phone including area code)

(Purchase Order No.)

May we make your name/address available to other mailers? YES ☐ NO ☐

Please Choose Method of Payment:

☐ Check Payable to the Superintendent of Documents

☐ GPO Deposit Account ☐☐☐☐☐☐-☐

☐ VISA or MasterCard Account

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐ (Credit card expiration date)

Thank you for your order!

(Authorizing Signature) 3/94

Mail To: New Orders, Superintendent of Documents
P.O. Box 371954, Pittsburgh, PA 15250-7954

ISBN 0-16-048065-5

Availability of Project Reports and Results

As extramural projects are competed, the final reports are placed with the National Technical Information Service (NTIS) for public access. For those projects with final reports at NTIS, the accession number for ordering purposes is given in the project writeup. Reports are available in hard copy or microfiche form; costs vary depending on the size of the reports. Further information may be obtained from: National Technical Information Service, Document Sales, 5285 Port Royal Road, Springfield, Virginia 22161, (703) 487-4650.

A few final reports are published by the Health Care Financing Administration. These reports are available for sale from the U.S. Government Printing Office (GPO). Reports must be ordered by title and stock number directly from GPO. For those projects with published final reports, ordering information is given in the project writeup. Send check or money order for the price listed and make payable to: Superintendent of Documents an mail to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954.

In addition, results from intramural and extramural research projects and demonstrations are often featured in the *Health Care Financing Review*, the Agency's quarterly journal. The journal also offers synopses on newly awarded research and demonstration projects being funded by the Health Care Financing Administration. The *Review* is available on a subscription basis from the Superintendent of Documents for $19.00 ($23.75 foreign). Subscribers receive four quarterly issues and one annual single-theme supplement per year.

U.S. Department of
Health and Human Services
Health Care Financing Administration
Room 2230 Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207